Commonwealth of Virginia
Department of Mental Health, Mental Retardation, and Substance Abuse Services
FFY 2004 PATH Application

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## PROJECT NARRATIVE AND SUPPORTING INFORMATION

### Section A: Executive Summary

Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) Community Support Services (CSS) has provided homeless services under PATH since 1991. Virginia's application for FFY 2004 is to continue the current eighteen projects and to expand the program with three new PATH sites. Virginia's PATH program will partner with the Virginia Department of Housing and Community Development (DHCD) in initiating a housing first program. DHCD is committing $500,000 in HOME funds to support housing assistance to homeless services providers who are able to provide the supportive services required to achieve the goals of this program. In the three areas that DHCD grants this pilot project, PATH Virginia will establish a new PATH site or expand the existing PATH services in the area. These PATH sites will be responsible for outreach, case finding, benefits acquisition, and transition of PATH consumers into the housing first program as well as other traditional PATH services.

**1) Organizations to receive funds (see table below)**

**2) Service Areas (see table below)**

**3) Services to be supported by PATH funds:** Outreach, screening and diagnostic treatment services, habilitation and rehabilitation services, community mental health services, alcohol and drug treatment for persons with severe mental illness, staff training, case management, supportive and supervisory services in residential settings, referrals for primary health care, job training, educational services, and relevant housing services.

**4) Numbers of persons to be served. (see table below)**

| PATH Provider Organizations | CMHC or PNP | Base Funding | Outcome Incentive | Total PATH Budget | Service Area | Clients to be Served |
|---|---|---|---|---|---|---|
| Alexandria CSB | CMHC | $42,778 | $7,549 | $50,327 | Alexandria | 138 |
| Blue Ridge CSB | CMHC | $36,190 | $6,386 | $42,576 | Roanoke & Salem. Craig, Botetourt & Roanoke Co's. | 218 |
| Carpenter's Shelter | PNP | $30,178 | $5,326 | $35,504 | Alexandria | 200 |
| Central Virginia CSB | CMHC | $28,411 | $5,014 | $33,425 | Lynchburg & Bedford. Amherst, Appomattox, Bedford & Campbell Co's. | 80 |
| Community Residences | PNP | $53,765 | $9,488 | $63,253 | Arlington Co. | 95 |
| District 19 CSB | CMHC | $33,068 | $5,836 | $38,904 | Petersburg, Colonial Heights, Emporia & Hopewell. Dinwiddie, Greensville, Prince George, Surry & Sussex Co's. | 118 |
| Fairfax-Falls Church CSB | CMHC | $131,407 | $23,190 | $154,597 | Fairfax & Falls Church. Fairfax county. | 535 |
| HamptonNNews CSB | CMHC | $78,282 | $13,815 | $92,097 | Hampton & Newport News | 300 |
| Loudoun County CSB | CMHC | $28,548 | $5,038 | $33,586 | Loudoun County | 84 |
| Norfolk CSB | CMHC | $64,988 | $11,468 | $76,456 | Norfolk | 161 |
| Northwestern CSB | CMHC | $17,921 | $3,162 | $21,083 | Winchester. Clarke, Paige, Frederick, Shenandoah & Warren Co's. | 123 |
| On Our Own. | PNP | $19,996 | $3,529 | $23,525 | Charlottesville. Albemarle, Green, Nelson, Fluvanna & Louisa Co's. | 175 |
| Portsmouth DBHS | CMHC | $44,768 | $7,900 | $52,668 | Portsmouth | 336 |
| Prince William County CSB | CMHC | $32,451 | $5,727 | $38,178 | Manassas & Manassas Park. Prince William County. | 166 |
| Rappahannock Area CSB | CMHC | $18,627 | $3,287 | $21,914 | Fredericksburg. Spotsylvania, Stafford, Caroline & King George Co's. | 185 |
| Region Ten CSB | CMHC | $19,996 | $3,529 | $23,525 | Charlottesville. Albemarle, Green, Nelson, Fluvanna & Louisa Co's. | 78 |
| Richmond BHA | CMHC | $84,656 | $14,940 | $99,596 | Richmond | 295 |
| Virginia Beach CSB | CMHC | $41,570 | $7,336 | $48,906 | Virginia Beach | 85 |
| Subtotal | | $807,600 | $142,520 | $950,120 | | 3372 |
| New Project Sites | | | | 75,000 | To be determined | 200 |
| VA Dept. of MHMRSAS/CSS | | | | $35,880 | | |
| Total | | | | $1,061,000 | | 3572 |

**Section B: State-Level Information**

**1. Provide the State's operational definitions for the terms, below.**

**a. Homeless Individual**

The operational definition for determining who is homeless is derived from the McKinney legislation. The term **"homeless"** includes persons who lack a fixed regular and adequate nighttime residence. It also includes persons whose primary night-time residence is either a supervised public or private shelter designed to provide temporary living accommodations; an institution that provides temporary residence for individuals intended to be institutionalized; or a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings

**b. Imminent risk of becoming homeless**

The term **"imminent risk of becoming homeless"** includes persons who 1) have experienced chronic and continuing housing displacement, 2) are threatened with imminent loss of housing or eviction from their home or from overcrowded or "doubled up" housing and have no other housing resources or supports available, or 3) are being discharged from a psychiatric hospital and were homeless (or met criteria 1, above) upon admission and have no other housing resources or supports available at discharge. "Imminent" means within the next seven (7) days, but may occasionally refer to a slightly longer time.

**c. Serious mental illness**

The operational definition for "**serious mental illness"** is found in Virginia State Board Policy #1029, entitled "Definitions of Priority Mental Health Populations", (effective June, 1990), which, in effect, prioritizes the CMHS definition. Diagnosis, disability and duration are the three dimensions in the following definition:

**Diagnosis**

There is a major mental disorder, diagnosable under DSM-IV, which is a schizophrenic, major affective, paranoid, organic or other psychotic disorder, or a disorder that may lead to a chronic disability, such as a personality disorder. Individuals who are seriously mentally ill and who have also been diagnosed as having a substance abuse disorder or mental retardation are included.

**Severe Disability Resulting from Mental Illness**

The disability results in functional limitations in major life activities. Individuals typically meet at least two of the following criteria, on a continuing or intermittent basis for at least two years:

1. Is unemployed, is employed in a sheltered setting or supportive work situation, or has markedly limited or reduced employment skills or has a poor work history.
2. Requires public financial assistance for out-of-hospital maintenance and may be unable to procure such assistance without help.
3. Has difficulty in establishing or maintaining a personal social support system.

4. Requires help in basic living skills such as hygiene, food preparation, or money management.
5. Exhibits inappropriate social behavior, which results in demand for intervention by the mental health and/or judicial system.

**Duration**

Individuals are expected to require services of an extended duration or the treatment history meets at least one of the following criteria:

1. Has undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g. crisis response services, alternative home care, partial hospitalization or inpatient hospitalization).
2. Has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.

**d. Co-occurring serious mental illness and substance use disorders**

The operational definition for determining individuals with a "**co-occurring serious mental illness and substance abuse disorder"** is contained within the Virginia definition of serious mental illness. The DSM-IV criteria for substance use disorders is used to substantiate a determination of the presence of substance use and abuse in persons with mental illness.

**2. Indicate the number of homeless individuals with serious mental illnesses by geographic region for the entire state. Indicate how the numbers were derived. This information may be presented as a table. Indicate where the providers are located on a map.**

Current estimates of homeless persons with serious mental illness in Virginia is estimated to be 19,737 (method described below). Geographic regions for this report are identified by Community Service Board (CSB) service regions. There are 40 CSB's that cover the entire state. The estimate for each CSB service region is indicated on the table, next page. The geographic location and area is demonstrated on the map on the following page. In both the table and the map, PATH service areas are indicated with shading. Note that two service areas (Alexandria and Charlottesville) have two sites each in their service areas and Community Residences is a contracted service through Arlington CSB.

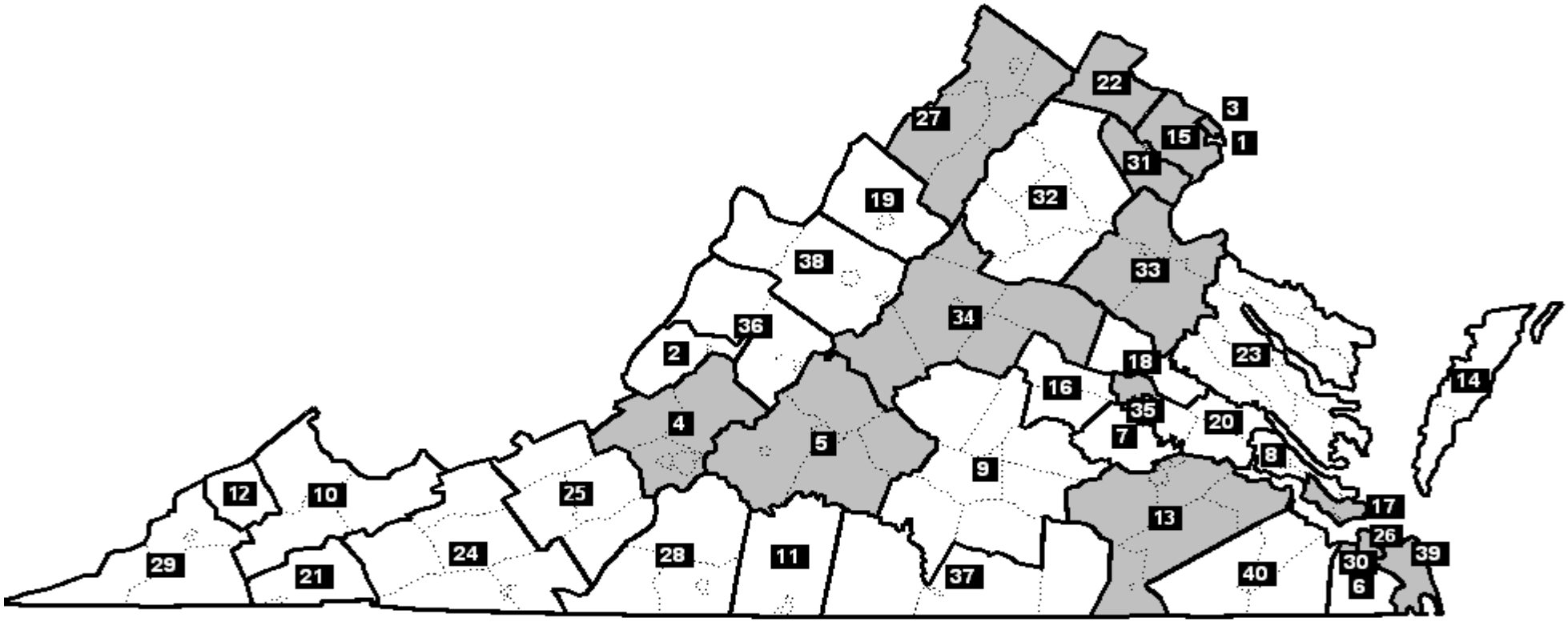
The Virginia Department of MHMRSAS compiles population estimates for each CSB service area and determines the estimated number of seriously mentally ill adults based in each area for the Comprehensive Plan. These estimates are based on the age specific prevalence rates of serious mental illness indicated in the National Household Survey on Drug Abuse (NHSDA) referenced in the Report of the New Freedom Commission on Mental Illness, "*Achieving the Promise: Transforming Mental Health Care in America" (2003).* The homeless / at-risk prevalence estimates are derived by taking 5 percent of the SMI population (Task Force on Homelessness, 1992 and Blueprint for Change, 2003). The table below represents the current estimates based on this methodology.

| Estimate of persons with Serious Mental Illness and Homeless or At Risk of Homelessness | | | |
|---|---|---|---|
| CSB NAME | POPULATION | SMI Adult Population Estimate | Homeless/At-risk and SMI estimate (5% of SMI) |
| Alexandria CSB & Carpenter's Shelter | 128283 | 8,093 | 405 |
| Alleghany Highlands CS | 23518 | 1,250 | 63 |
| Arlington CSB (Community Residences) | 189453 | 12,099 | 605 |
| Blue Ridge CS | 241023 | 13,148 | 657 |
| Central Virginia CSB | 228616 | 12,600 | 630 |
| Chesapeake CSB | 199184 | 10,537 | 527 |
| Chesterfield CSB | 259903 | 13,701 | 685 |
| Colonial MH/MR | 127963 | 6,999 | 350 |
| Crossroads SB | 97103 | 5,440 | 272 |
| Cumberland Mountain CS | 101884 | 5,708 | 285 |
| Danville-Pittsylvania CS | 110156 | 5,914 | 296 |
| Diskenson County CS | 16395 | 909 | 45 |
| District 19 CSB | 167129 | 9,239 | 462 |
| Eastern Shore CSB | 51398 | 2,710 | 136 |
| Fairfax-Falls Church CSB | 1001624 | 54,989 | 2,749 |
| Goochland-Powhatan CSB | 39240 | 2,163 | 108 |
| Hampton-Newport News CSB | 326587 | 18,488 | 924 |
| Hanover CSB | 86320 | 4,521 | 226 |
| Harrisonburg-Rockingham CSB | 108193 | 6,805 | 340 |
| Henrico Area MH/MR SB | 282688 | 15,508 | 775 |
| Highlands CS | 68470 | 3,820 | 191 |
| Loudoun County CSB | 169599 | 8,904 | 445 |
| Mid Peninsula-Nrthrn Neck CSB | 133037 | 7,002 | 350 |
| Mount Rogers MH/MR SB | 121550 | 6,700 | 335 |
| New River Valley CS | 165146 | 10,880 | 544 |
| Norfolk CSB | 234403 | 14,319 | 716 |
| Northwestern CS | 185282 | 10,016 | 501 |
| Piedmont CS | 140039 | 7,617 | 381 |
| Planning District 1 CSB | 91019 | 5,024 | 251 |
| Portsmouth DBHS | 100565 | 5,553 | 278 |
| Prince William CSB | 326238 | 17,456 | 873 |
| Rappahannock Area CSB | 241044 | 12,803 | 640 |
| Rapp-Rapidan CSB | 134785 | 7,115 | 356 |
| Region Ten CSB & On Our Own | 199648 | 11,651 | 583 |
| Richmond BHA | 197790 | 11,768 | 588 |
| Rockbridge Area CSB | 39072 | 2,665 | 133 |
| Southside CSB | 88154 | 4,784 | 239 |
| Valley CSB | 111524 | 6,067 | 303 |
| Virginia Beach CSB | 425257 | 23,509 | 1,175 |
| Western Tidewater CSB | 119233 | 6,274 | 314 |
| Total Population | 7078515 | 394,748 | 19,737 |

Notes:

1) SMI estimates in this chart are approximately 50% higher than previous years due to revised formula explained in narrative. It is expected that this new SMI formula may be producing inflated SMI Homeless/At Risk estimates in this chart.
2) Homeless/At Risk SMI numbers derived from 5% prevalence estimates (Blueprint for Change, 2003)
3) Shaded Areas = Current PATH Sites

**Virginia PATH Covered Service Regions**
**May 2004**




Community Service Board Service Area Identifications – Shaded Areas Indicate Current PATH Coverage Areas

1 Alexandria
2 Alleghany Highlands
3 Arlington
4 Blue Ridge
5 Central Virginia
6 Chesapeake
7 Chesterfield
8 Colonial
9 Crossroads
10 Cumberland Mountain
11 Danville-Pittsylvania
12 Dickenson
13 District 19
14 Eastern Shore
15 Fairfax-Falls Church
16 Goochland-Powhatan
17 Hampton-Newport News
18 Hanover
19 Harrisonburg-Rockingham
20 Henrico Area
21 Highlands
22 Loudoun
23 Mid Peninsula-Northern Neck
24 Mount Rogers
25 New River Valley
26 Norfolk
27 Northwestern
28 Piedmont
29 Planning District 1
30 Portsmouth
31 Prince William
32 Rappahannock-Rapidan
33 Rappahannock Area
34 Region Ten
35 Richmond
36 Rockbridge Area
37 Southside
38 Valley
39 Virginia Beach
40 Western Tidewater

**3. Describe how PATH funds are allocated to areas and local providers (e.g. through annual competitions, distribution by formula, or other means), including:**

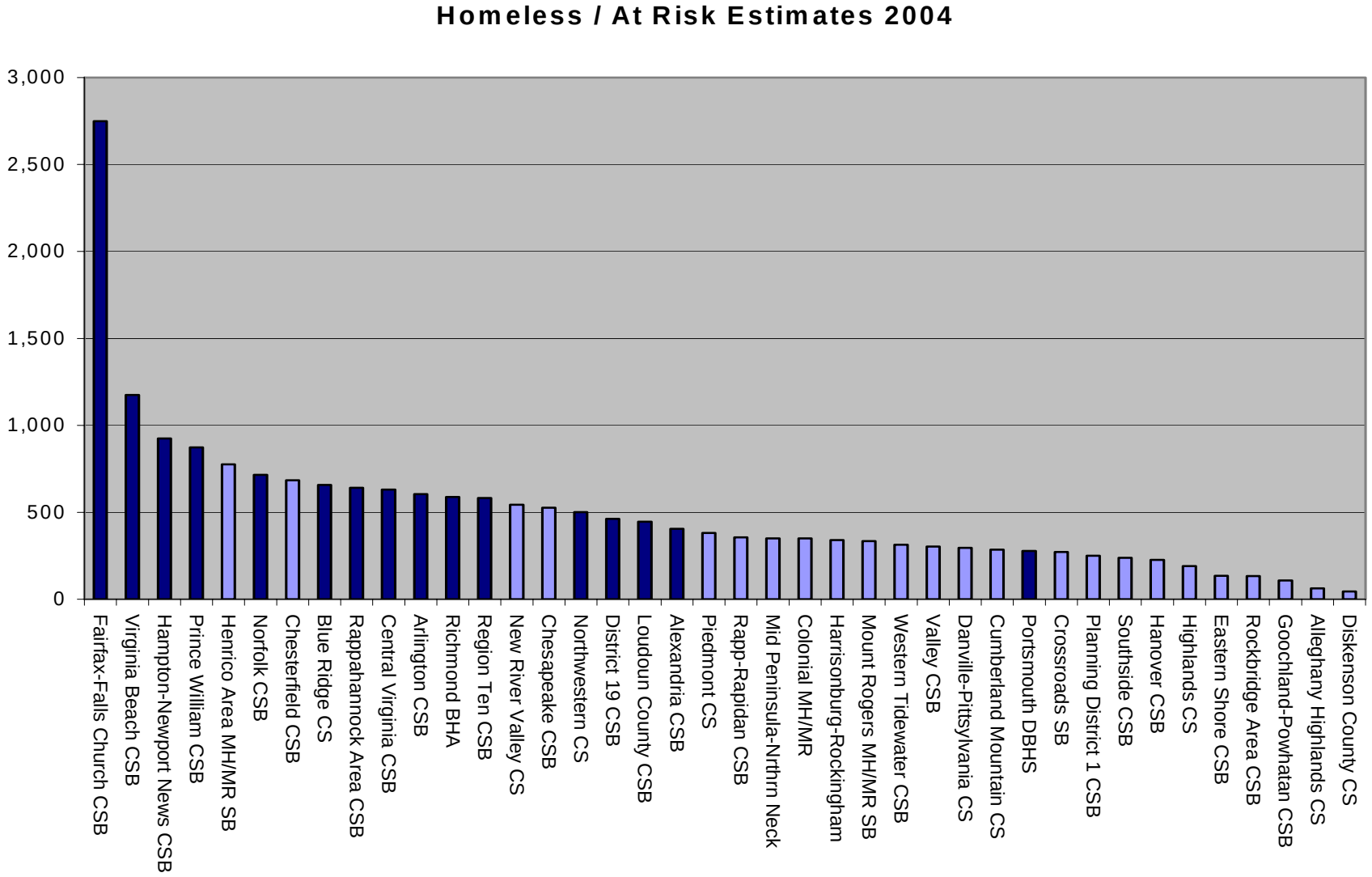
The PATH funds are allocated to sites using a formula that creates a need score for each of the PATH sites. This year the score was derived from the 2003 HUD defined Homeless Assistance Pro-Rata for each area and the PATH-targeted disabled homeless subpopulations reported to HUD by each community. In performing these calculations, we discovered that four out of 18 sites were significantly under-funded. In order to bring these sites within comparable funding ranges, adjustments were made to their allocations. The remaining sites were awarded a 2% cost of living increase. The formula changed this year in response to the 2003 change in the way HUD captures need data from communities. The sites that receive a significant increase will be expected to use the additional funds to increase staff time for outreach, benefit acquisition services (especially SSI), and housing acquisition – priority areas of the PATH program.

Since FY2002, a performance incentive pool of 15% of the total site awards has been used and allocated based on quarterly performance scores. We will continue with this established process this year. This process is outlined in following sections.

Finally, we plan to set aside $75,000 of the PATH award for a special project with DHCD in response to an initiative from the Homeless Policy Academy. For this initiative, DHCD is using a $500,000 set aside of HOME funds to provide tenant-based rental assistance for pilot "Housing First" programs in non-entitlement communities. For each of the expected three (3) communities awarded, PATH will provide an award to establish a PATH site in the community or expand PATH if the community has an existing PATH site. This award will be used to provide outreach, case finding, benefit acquisition, and housing transition support services for the pilot housing program as well as traditional PATH services.

**a. how the allocation is related to the need for services described in Section B.2, above**

PATH sites are either within or adjacent to the areas of high PATH eligible populations. PATH sites cover all major metropolitan areas. This year, PATH sites are covering 62% of the population through their coverage areas. There are four CSB service areas that have significant estimates of a homeless SMI population but are not PATH sites (see chart below). Chesterfield and Henrico Counties are suburbs of the City of Richmond. This year we have significantly increased funding to the Richmond site, which reports that they serve persons from these areas as they come to Richmond to seek shelter and services. Chesapeake is adjacent to Norfolk and has no shelter services for single adults other than a winter hypothermia shelter that is operated with Norfolk groups. The Norfolk site serves a high portion of Chesapeake residents as they seek shelter in Norfolk. Norfolk's funding was also increased this year. The New River Area is adjacent to the Blue Ridge/Roanoke area, the hub for homeless services in the central western area of the state. Blue Ridge also received a funding increase this year. Arlington also received a significant adjustment this year as their need score indicated that the area could benefit from increased PATH services. OMH will continue to evaluate the need in non-PATH areas of the state to determine whether PATH services should be considered and if there is a willing provider in these areas. These results will be included in FFY05 planning.




**1) Darker columns indicate current PATH sites. This chart based on table page 8 in this text.**

**b. how the State gives special consideration in awarding PATH funds to entities with a demonstrated effectiveness in serving homeless veterans**

PATH sites in Virginia are appropriate service sites to address the needs of veterans in two ways:
1) veteran population for the areas, and
2) coordination of services for homeless veterans.

**Population**

Tidewater Area: The 2000 Census reports that the population of veterans in the PATH sites areas of Tidewater are Hampton 27.1%, Newport News 19.9%, Norfolk 19.9%, Virginia Beach 21.7%, and Portsmouth 18.4%. Each of these areas were listed in the "Ten Places of 100,000 or More with the Highest Percentage of Veterans in the Civilian Population Aged 18 and over: Census 2000". It was also noted that these areas had high percentages of Vietnam Era and Gulf War Veterans.

Northern Virginia Area: PATH sites in this area cover areas with a high veteran population. Rappahannock Area CSB covers counties with 15.5 – 25.5% veteran population. Northwestern and Prince William County cover areas with 15.5-17.7% veteran population.

Central and Southern Virginia Area: District 19 CSB, Richmond, Region Ten, and Central Virginia CSB cover city/counties with 15.5-17% veteran population.

Western Area: Blue Ridge CSB covers city/county areas with 15.5-17% veteran population. (Source: 2000 Census Reports, TM-P044 and Veterans 2000: Census 2000 Brief www.census.gov)

**Coordination of Services**

PATH sites are expected to assess the best delivery of services for veterans in their area. In some cases it works best to coordinate services with the local VA outreach representative, who can provide them with quicker access to care, flexible service delivery, assistance with VA and SSI benefits, and can provide additional housing and supportive recovery options. It is usually in the best interest for the client not to be served directly by PATH or the CSB, but for PATH to assist the person in making a good connection with the VA representative and tracking the progress that the person is making. If the connection is not successful, the PATH worker can pick the client back up on their caseload and then serve them through outreach and move them into mainstream services on the civilian side.

PATH sites are encouraged to have a working relationship with either their closest VA hospital Clinic or the VA Outreach worker for their area. As a result, PATH has noticed a solidifying of relationships with the veteran's service organizations. PATH sites were asked to describe how they provide services to this population. Their answers are provided this year. The following table provides their responses. A note of interest is that providers are reporting an increasing need to serve non-service connected veterans as the VA Hospital clinics are cutting back on services for this population.

| PATH Site | Description of Services Provided to Veterans |
|---|---|
| Alexandria | The Homeless Services Coordinator provides direct services to homeless veterans. Many homeless veterans utilize David's Place, the local drop-in center for homeless adults. The Homeless Services Coordinator conducts outreach to this population and links the |

| | |
|---|---|
| | consumer to an outreach Clinical Social Worker employed by the Department of Veterans Affairs. |
| Blue Ridge Behavioral Health (BRBH) | Homeless veterans who have a mental illness or a substance abuse problem who are enrolled by the PATH staff have access to the same array of BRBH-provided case management and treatment services as other identified individuals. As veterans, they also have access to services available to homeless veterans at the Veterans Affairs Medical Center in Salem, VA. These veterans are provided a choice of primary provider. Identified homeless veterans who do not have a mental illness or a substance abuse problem are referred to staff of the VAMC Program for Homeless Veterans. |
| Carpenter's Shelter | Outreach workers from Martinsburg, West Virginia Homeless Domiciliary Program are on site on a weekly basis to assist veterans with benefits, medical treatment, mental health, substance abuse treatment, housing, and transportation. Homeless veterans are also provided with transportation to the Veterans Center in Washington D.C. via bus tokens and metro cards. |
| Central Virginia | Strategies for providing services to homeless veterans include the PATH coordinator acting as a conduit to the Salem Hospital Veteran Administration to assist homeless veterans in accessing services. |
| Community Residences (Arlington CSB) | Strategies for providing services to homeless veterans: The HCM program has recently seen an influx of homeless or soon to be homeless veterans. The program refers persons to the Veterans Administration (VA) and will accompany persons during that assessment. If the person is open to working with the VA, staff works closely with the consumer to help access VA benefits. The HCM program has recently started to market HCM services to organizations working with homeless veterans from Arlington County, such as: Veterans Administration Hospital, the Veterans Outreach Center, and the local homeless shelters. |
| District-19 | To provide services to homeless veterans, the PATH program will begin by actively attempting to identify which homeless persons are also veterans. Once the identification has been made, PATH will notify the VA's McGuire Hospital Homeless Outreach Services which in turn will come on site to link the veteran to VA provided medical services, SA services, shelter and transitional housing. |
| Fairfax Falls Church | One strategy is to first of all ask if the person is a veteran, so our workers do this on a regular basis. Secondly, providing very active case management is a must in order to access as many benefits as possible from the Veterans' Administration. We provide transportation and support adding up to significant hours for those in need simply to get to the area VA hospitals, offices, etc. For example, Walter Reed Army Medical Hospital, where some vets get their prescriptions, is an hour away on a good day, and usually much longer given the traffic.<br><br>Secondly, there is a veteran's outreach worker in the Fairfax County catchment area. The PATH workers have utilized his knowledge and he has assisted in getting individuals set up with services or benefits through his contacts. Furthermore, this writer worked at a Veterans hospital and I have used my knowledge of the VA hospital system to provide individuals with information and/or referrals. With veterans, like other consumers, each worker ensures that they perform a comprehensive assessment to work with the consumer in making a determination about the best course of treatment for the vet. The PATH workers have knowledge of the different treatment programs |

| | |
|---|---|
| | available at the local veteran's hospital and make appropriate referrals when needed. |
| Hampton Newport News | The Hampton-Newport News Community Services Board is located near the Hampton Veteran's Medical Center. The PATH case manager works closely with the Health Care for Homeless Veteran's program and staff, helping to identify eligible veterans for outreach, referrals, assessments and services. PATH staff coordinates with the VA Center for placement in their Domiciliary Program. The Salvation Army runs a 60-bed shelter on the site of Veteran's Center for homeless veterans. Referrals have been made to these programs and the PATH worker has assisted veterans with traditional housing applications mentioned in the above section. Again, the PATH case manager advocates for all homeless mentally ill clients. Frequent contact is made with the Veterans Medical Center Staff through the Continuum of Care network of providers. In the past, HNNCSB was a contract provider of residential services to veterans through the VA Per Diem grant program. The VA initiated a change to this program resulting in the loss of all contract providers in the state of Virginia for such services. This has resulted in the termination of the contract between the HNNCSB and the VA. However, through other referral mechanisms, HNNCSB will continue to offer housing to veterans as appropriate. |
| Loudoun | Engaged homeless veterans are provided with referrals to regional and national Veterans Affairs Administration offices and transportation to appointments. Consumers are provided with contact information to apply for the Veterans Administration of Martinsburg, WV Homeless Program. The program provides case management, mental health services, housing services, employment referrals, education and training, support for entitlement application process, and assistance with transition from homelessness. |
| Norfolk | Norfolk PATH worker has a long-established relationship with the Veterans Administration's outreach program for mentally ill veterans. Both Norfolk PATH and the VA coordinate service delivery and outreach efforts to this population. The VA has a regular weekly outreach site and has drop-in service available weekdays for benefit information, case management, and clinic service access. |
| Northwestern | Aggressive outreach will be provided by The Northern Shenandoah Valley Homeless Network, veteran organizations, churches, social service organizations, hospitals, and other community action resources to engage homeless veterans in needed services. This outreach will be accomplished through street canvassing, canvassing soup kitchens, abandoned buildings, food pantries, and emergency shelters. There is a 24-hour hotline available to homeless veterans and the Veterans Medical Center in Martinsburg, WV provides services to homeless veterans and maintains a domiciliary care unit.<br>There are also Veteran's Outreach Centers within the planning district, which serve veteran's needs on an outpatient basis. Services will include permanent housing, mainstream health and social services benefits, and job training/employment services. |
| On Our Own | For PATH clients who are veterans, all agency services are available. Veteran specific services are provided by the VA hospital located in Richmond who has a representative that provides services in the Charlottesville area. |
| Portsmouth | PATH workers provide outreach, link to VA outreach workers and to VET's House. Recent cutbacks in services available through the local VAMC have required that the PATH worker provide civilian services |

| | |
|---|---|
| | in an increasing amount to veterans. |
| Prince William | The PATH staff coordinates with other outreach programs to link veterans to the Veterans Administration (VA). This includes intensive outreach, and when the client is open to the possibility, often after several years, linking and coordinating with the VA. The process of getting a case open often involves a good deal of contact with VA staff prior to the first appointment. Once an appointment can be obtained then the PATH person walks the client through the rest of the process. Transporting to the VA in Washington, DC, going with clients to advocate and support them in this complicated process. |
| Rappahannock Area | PATH staff will provide homeless veterans who are PATH eligible with information on local veteran services including the medical clinic. PATH staff will assist veterans in linking to available services. Transportation including the use and purchase of tickets on the public bus system will be provided to the medical clinic. |
| Region Ten | The overall numbers of homeless veterans encountered by the Region Ten PATH program have remained extremely low. This is the case though staff maintain, as described, active outreach and high visibility in the community. No special strategies have been deemed necessary at this point. The project maintains close coordination with the Continuum of Care committee of the Coalition for the Homeless to assure that opportunities to engage this group are not missed. The Veterans Administration is represented on this TJACH continuum of care committee. |
| Richmond | Currently, the RBHA is forming a collaboration with the staff at the Veteran's Emergency Shelter and is scheduled to conduct trainings on homeless outreach services with the staff at McGuire Hospital. |
| Virginia Beach | The PATH worker refers to Vets House for transitional housing. The PATH worker links with the Veterans Affairs Outreach worker for referrals. |

**4. Indicate how the services to be provided using PATH funds are consistent with the State comprehensive mental health services plan.**

The State Mental Health Block Grant Plan references the development and implementation of performance and outcome measurements for the PATH program (as described herein) and the monitoring of a composite score among PATH providers for the number of consumers who receive mental health services (including outreach), shelter, and housing assistance.

**5. Indicate whether (a) mental health block grant, (b) substance abuse block grant, or (c) general revenue funds are designated specifically for serving people who are homeless and have serious mental illnesses.**

State general revenues are used to support services targeted to persons who are homeless and have serious mental illness. DMHMRSAS provides funds to Community Service Boards through the Mental Health Residential Supports Program. This funding can be used to provide direct services, housing supports, match for HUD Continuum of Care projects, and other services for homeless consumers with serious mental illness. In addition, Community Service Boards are funded with State general funds, which may be used directly to match PATH program services in those areas that have PATH sites. No mental health block grant or substance abuse block grant

funds are specifically designated for serving persons who are homeless and have a serious mental illness, however they do support services to consumers who are identified and referred through PATH.

**6. Describe how the State will provide programmatic and financial oversight of the PATH-supported providers, such as site visits, evaluation of performance goals, audits, and so forth. In cases where the State provides funds through intermediary organizations (e.g., county agencies or regional behavioral health authorities), describe how these organizations conduct monitoring of the use of PATH funds.**

The PATH Program is administered through Community Support Services (CSS), a section of the Office of Mental Health within DMHMRSAS. Financial oversight is provided by the Department's Fiscal Office through a standard Performance Contract with CSBs and individual contracts with non-profit contractors. This year the CSS specialist was hired to oversee this program. The department had been without a specialist for two (2) years due to budget cutbacks and the Director of CSS has assumed these duties during this time. This position provides ongoing oversight and assistance to the eighteen PATH sub-grantees under the supervision of the Director of the Community Support Services.

The Community Support Specialist will review program applications and annual reports, monitor the quarterly incentive program (described below), assist sites with new staff with program development and transition, provide technical assistance by telephone and written correspondence and (at least annual) on-site monitoring and technical assistance visits. The CSS Director and the CSS specialist also assist in inter-agency communications and network building, assist in accessing housing development & supports funding, represent the Department on the Virginia Interagency Action Council for the Homeless and other coordinating bodies, serve as the state PATH contact for sub-grantees, serve on the Virginia Homeless Policy Academy, and work with the Mental Health Planning Council regarding PL 102-321.

For the one site that is a contract through the regional behavioral health authority (CSB), CSS directly monitors the site that is providing the services. Contact is made with the CSB contracting agency related to matters of applications, oversight, and financial issues.

**PATH Program Quarterly Performance Reporting**
The following PATH Program Quarterly Performance Report (with accompanying instructions that follow) is completed by PATH Project sites and is used to monitor progress and determine the allocation of performance awards. The Virginia PATH Performance Incentive program sets aside 15% of the federal PATH award for each site as a "Performance Incentive Fund". Performance Incentive funding is awarded on the basis of quarterly performance as measured by each sites' submission of a Quarterly Performance Report to the Department.

A "Performance Target" is assigned to each PATH site annually. This target score is based on past performance, amount of funding, and proposed number of enrollment. The score is divided by 4 to arrive at a "Quarterly Performance Target", which is the level of achievement that must be attained in order for the site to be eligible for the Performance Incentive funds. A PATH site

is awarded one-fourth of the 15% set-aside for each quarter in which they achieved their established Quarterly Performance Target.

The "Quarterly Performance Score" is derived from the performance indicators provided in each sites' Quarterly Report. Our performance indicators can be grouped into three domains; Outreach, MH Services, & Housing Services. Within these domains are the measures described below:

| | |
|---|---|
| **Outreach** | # of people outreached (or referred to the PATH program). |
| **MH Services** | # of people referred to MH services |
| | # of people placed in MH services |
| **Housing** | # of people placed in shelter |
| | # of people referred to housing |
| | # of people placed in housing |

The sum of all the indicators provides the total performance score for that quarter, which is compared to the Quarterly Performance Target for each site. The process is not only an incentive for performance, but also a program evaluation tool.

**PATH Quarterly Performance Report Form** PATH Agency: Report Quarter: Year

## A. Outreach Activities - *This Quarter Only*

| | | | | | |
|---|---|---|---|---|---|
| *1a* | Number of persons outreached? | **Outreached:** | | **Referred/Walk-in:** | |
| *1b* | Number of outreach contacts made? | **Outreach:** | | **Referral/Walk-in:** | |

## B. Enrollment - This Quarter Only

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| *2a* | How many consumers were enrolled this quarter? | **New:** | | **Old:** | | **Repeat:** | |
| *2b* | How were the PATH clients in 2a initially contacted? | **Outreached**: | | | | **Referred/Walk-in:** | |
| *2c* | Of the persons in 2a, how many were Unengaged? | **New:** | | **Old:** | | **Repeat:** | |
| *2d* | What was the housing status of the persons listed in 2a? | | | | | | |
| | Outdoors | | | Short term shelter | | Long-term shelter | |
| | 1/2 way house/treatment prog. | | | Apartment, room, or house | | Hotel, SRO, boarding house | |
| | Psych/Medical Institution | | | Jail/correctional facility | | | |

## C. Housing Referral and Placement - Activities in this quarter on behalf of enrolled client only

| | | | | | |
|---|---|---|---|---|---|
| *3a* | How many enrolled persons were placed in shelter this quarter? | **Traditional:** | | **Non-Traditional:** | |
| *3b* | How many Placements occurred for the clients listed in 3a? | **Traditional:** | | **Non-Traditional:** | |
| *4* | How many persons Enrolled PATH clients applied for housing this quarter? | **Clients applying:** | | **Applications submitted:** | |
| *5a* | How many Enrolled PATH clients were referred to/placed in housing this quarter? | **Clients referred:** | | **Clients placed:** | |
| *5b* | Of the clients in 5a, what was the average time (in months) from first application to placement? | **Average Wait Time**: | | | |

## D. Referral Activities

| | | | | | |
|---|---|---|---|---|---|
| *6a* | Enrolled PATH clients given referrals this quarter. | **Number of Persons:** | | **Total Referrals Provided:** | |
| *6b* | Outcome of "Total Referrals Provided" in 6a. | **Successful:** | | **Unsuccessful/Unknown:** | |
| 7a | Enrolled PATH clients referred to/placed in MH Services this quarter? | **Clients referred:** | | **Clients placed:** | |

## E. Concrete Services

| | | | |
|---|---|---|---|
| *8* | How much was spent in this quarter on concrete services? (Round to nearest dollar) | **Total Concrete Services Expenditure**: | |
| *9* | What were the three most commonly used tangible items? | **Item 1**: | |
| | | **Item 2**: | |
| | | **Item 3**: | |

# Definitions:

| | |
|---|---|
| ALL Enrolled PATH Clients | The term "All" Enrolled Clients refers to the total group of persons who are actively Enrolled PATH Clients in the program at that point in time. This includes all persons enrolled during the program year to date AND those carried over from the previous year. "Active" refers to your present open caseload of Enrolled Persons. |
| Enrolled PATH Client or PATH Client | A person is Enrolled when a formal record has been opened or a plan developed. Prior to this event, they are *Non-Enrolled recipients of PATH services*. |
| Graduated PATH Client | An **Enrolled** PATH Client who has, in the estimation of the PATH worker, *successfully* completed their goals within the PATH program and is no longer requires ongoing PATH services. The specifics of this event differ between sites, but usually should be clearly defined within each site. When this event occurs, the PATH Client's case is usually closed. |
| New (Enrolled Clients only) | An Enrolled Client is "New" when they have never been Enrolled in the PATH program before. |
| Non-Enrolled or Non-Enrolled Recipient of PATH services | A person believed to be eligible for PATH but not yet Enrolled, who receives PATH outreach services. While Enrolled PATH Clients are also recipients of PATH services, the term Enrolled is used to differentiate them from Non-Enrolled recipients of services. |
| Old (Enrolled Client only) | There are **two conditions when an Enrolled Client is determined to be "Old"**; the first is when Enrolled PATH Clients are carried over from one fiscal year to the next. All Enrolled PATH Clients in a PATH program on the last day of the fiscal year are considered to be "Old" on the first day of the new fiscal year. The second condition applies when an Enrolled PATH Client self-terminates or otherwise "drops out" of the PATH program and then returns at a later date and becomes Enrolled. |
| Repeat (Enrolled Client only) | An Enrolled PATH Client is considered to be a "Repeat" when they have previously "Graduated" from the PATH program and have now become Enrolled in the PATH program for another term of services. |
| Unengaged (Enrolled Clients only) | Unengaged refers to the Enrolled Client's status at first contact and means that the last Mental Health System service date was six months or more in the past AND that service was other than Emergency only, Detox only, or Short-term Hospitalization (e.g. TDO) only. Mental Health System includes any public or private mental health service provider. |

**7. Indicate whether the State provides, pays for, or otherwise supports training for local PATH-funded staff.**

Virginia DMHMRSAS, OMH provides ongoing training opportunities for PATH staff. Over the past year, the focus of state sponsored training has been to assist PATH providers in their knowledge, skills, and abilities related to assisting persons apply for, acquire, and maintain SSI & SSDI benefits. A series of three day-long intensives on determining medical eligibility for PATH clients in the SSI process was provided through the state office by bringing Yvonne Perret, a nationally recognized expert in the field, to regional trainings. Starting in May 2004, a statewide series of four day-long workshops is co-sponsored by OMH to provide "Assisting Homeless Persons with the SSI & SSDI Process". Social Security Administration, Department of Rehabilitation Services, and DMHMRSAS are providing training for these workshops. The focus of this is to improve the skill level of workers with the application process and skills specific to persons with mental illness.

OMH also has recently hired a PATH administrator. Since February 2004, this new staff has been going onsite to PATH sites to assist them with training that is specific to the needs of that site. These technical assistance visits focus on helping educate the staff on PATH service specific expectations, reporting, case documentation, building outreach services for those most difficult to reach, and coordination with local Continuum of Care groups.
OMH keeps PATH sites up to date through email notices of training and conference calls available through PATH national training resources. OMH will be providing a training conference for PATH sites in November 2004. The focus of this conference will be to refresh sites in program areas noted in the technical assistance visits, work on reporting, standardizing definitions, and provide training specific to benefits and housing rights.

PATH sites benefit from email announcements by the CSS specialist of upcoming trainings that are available. This year PATH directly funded the following: Medical Eligibility for SSI, SSI & SSDI Eligibility Training for the Chronically Homeless, and have planned the PATH Virginia Conference for November 2004. PATH sites are encouraged to include training funds in their PATH budget. In addition, OMH is working on a training incentive fund to assist sites in affording to attend national and other conferences that they would not normally be able to afford. PATH site staff have participated in the past year or are scheduled to attend the following trainings: Medical Eligibility for SSI; Dual-Diagnosis Training; SSI & SSDI Eligibility Training for the Chronically Homeless; Assessment and Diagnosis in Homeless Shelters; State Hospital Discharge Planning; Continuum of Care Training for Rural Communities; Fair Housing; Social Work Practice in Health and Mental Health Care; Outreach Practices Teleconference; National Housing First and the 10 year plan Conference and Teleconference; Virginia Coalition for the Homeless Annual Conference; Healthcare for the Homeless Conference; Men, Trauma & Homelessness Teleconference; Virginia Policy Academy Housing First Teleconference; Ethics in Allocating Scarce Resources; SSI, SSDI & Work Incentives; and Preventing Homelessness through Discharge Planning in the Corrections System. Sites also report numerous local homeless training events hosted by their local HUD Continuum of Care groups.

**8. Describe the source of the required matching non-Federal contributions and provide assurances that these contributions will be available at the beginning of the grant period. Matching in-kind funds may be used only to support PATH-eligible services.**

PATH providers contribute local resources from state and local public funds as well as private donations, in cash and in-kind services and supplies, to make up the required non-Federal match. Each site provides a written assurance that the matching resources will be available at the beginning of the grant period.

**9. Describe the process for providing public notice to allow interested parties, such as family members, consumers, and mental health, substance abuse, and housing agencies, and the general public concerning the proposed use of PATH funds (including any subsequent revisions to the application). Describe opportunities for these parties to present comments and recommendations prior to submission of the State PATH application to SAMHSA.**

The PATH 2003 application has been posted on the state website for comment since February 2004. Notices were delivered to stakeholders via email lists that the plan was available for comment and would be used in the development of the 2004 application. In March 2004, OMH met with the Virginia Department of Housing and Community Development to discuss ways in which PATH could deliver services in a way that would promote increased opportunities for housing for this population. As a result, a plan was developed to initiate three new PATH sites in communities that would also be pilot areas for the DHCD "Housing First" program. It is expected that these sites will be in non-entitlement areas and at least two of these sites will be in rural communities. In April 2004, OMH staff presented the 2004 plan for PATH services to the Mental Health Planning Council, the state's consumer and family member advisory committee in the development of mental health services planning. The plan was also presented to a statewide meeting of non-profit and faith based substance abuse service organizations in May 2004. Once OMH has finalized the application for this year, this plan will replace the one currently on the website and will be available for public comment. Any comments received will be taken into consideration for this and next year's PATH plan and recommendations for substantive changes will be reported to CMHS for review.

**Section C: Local Provider Intended Use Plans**

Intended use plans for all 18 sites are included on the following pages. Intended use plans for the three sites to be awarded after DHCD selects the communities will be provided to CMHS for review at that time. Each site will be expected to provide the type and level of service similar to existing sites of similar size and geographic type.

**INTENDED USE PLANS: VIRGINIA PATH SITES FFY04 / SFY05**

**1. <u>Provider Organization:</u>**
The **Alexandria Community Services Board** provides mental health, substance abuse and mental retardation services to the residents of The City of Alexandria.

**2. <u>Path Funds</u>:**
The Alexandria Community Service Board PATH budget for FY 2005 is $110,039. The PATH funded amount is $50,327. State and local funding resources provide the match of $59,712. The matching funds will be available July 1, 2004.

Line item description for FY 2005 budget follows:

- Therapist III salary: [redacted] and related employee benefits: [redacted].
- Outreach and travel to state meetings and training: $[redacted].
- Training provided by external agencies: $[redacted]
- Program supplies, such as bottles for drug screens and printed materials: $[redacted].
- Emergency housing and one-time rental assistance assists individuals in an attempt to avoid being a long-term PATH consumer. The rental assistance is given one time to prevent eviction. Funding for emergency housing includes payment to local motels for short period of time, primarily utilized by individuals not able to utilize shelters too compromised to live outdoors. Amount: $[redacted].
- Bus tokens and subway rail passes: $[redacted].
- Non-program administration expenditures include PATH program share of the Extended Care Division and CSB's administration costs: $[redacted].
- Drug screens and medications: $[redacted].
- Office space and building maintenance: $[redacted].

**3. <u>Services Plan</u>:**

**a.** The Alexandria Community Services Board PATH program projects to serve 138 consumers during FY 2005. The percentage of this population thought to be literally homeless (outdoors, short-term, long term shelter) is estimated to be approximately 65%.

**b.** Specific services to be provided include:
<u>Outreach</u>: The Homeless Services Coordinator makes routine visits to local shelters, David's Place, soup kitchens and other places commonly known to have a large proportion of homeless individuals. The coordinator offers increased visibility and accessibility to mental health services by using the community -based, rather than Center-based, approach. The focus at this early stage is one of engagement. The Homeless Services Coordinator makes unscheduled visits to riverbanks, local libraries, wooded areas, and bridge overpasses in an attempt to assess the needs of potential PATH consumers not utilizing mainstream / traditional services.

<u>Screening and Diagnostic Treatment</u>: The Homeless Services Coordinator screens all referrals and contacts made in the community for the PATH Program. The coordinator

gathers and documents a comprehensive diagnostic history and assessment based upon interviews with the individual and documentation received from other sources.

Community Mental Health: All PATH consumers are entitled to the full benefits and services of resources available to them within the Alexandria Community Services Board. The coordinator makes recommendations based upon the information gathered in the assessment process. Referrals are made within and outside the agency. This would include psychiatric evaluation, psychological testing, and substance abuse referral, case management through Case Management Unit (CMU), and individual or group therapy.

Alcohol and Drug Treatment: Based upon information gathered during the assessment process, the Homeless Services Coordinator will make recommendations and referrals regarding alcohol and drug treatment for consumers who are dually diagnosed.

Staff Training: Staff training is provided to local shelter directors, case managers and other front-line staff who have frequent interaction with PATH consumers. The focus of the training is to address issues specifically related to providing quality services to shelter residents with a mental illness. The coordinator takes all new mental health staff, including interns, to the local shelters. This provides a better understanding to the staff person of what the potential shelter experience will mean for their client. The staff person will likely know their client's strengths and weaknesses and to whether the shelter referral is appropriate or if an alternative approach is necessary.

Case Management: All PATH consumers receive case management services, whether it is from the Homeless Services Coordinator or case managers from CMU or other programs affiliated with the Alexandria Community Services Board.

Referrals for Auxiliary Services: All PATH consumers are referred to general services such as primary healthcare providers. Consumers with adequate health insurance are referred to private physicians as appropriate, while consumers with no insurance and/or little income are referred to Casey Clinic. Consumers are encouraged to have routine HIV and TB tests. The case manager will often accompany the consumer for both testing and obtaining results.

Housing Services: PATH funds, in the form of emergency financial assistance, have been allocated to help consumers with shelter expenses (for example, when shelter space is not available for that person), storage facilities, and consumer transportation. PATH funds are available for a one-time rental payment to prevent eviction for the SMI individual at risk for homelessness. The Homeless Services Coordinator advocates for the consumer with all available housing resources that may be available to the consumer.

**c.** Community organizations providing key services to PATH consumers:
The Homeless Services Coordinator primarily utilizes three shelters within the City of Alexandria for PATH consumers. Staff from Carpenter's Shelter, Alexandria Community Shelter, and ALIVE! House work closely with the Homeless Services

Coordinator in assisting established consumers and helping to identify potential consumers of PATH funds. PATH consumers will be referred to shelters outside of the City of Alexandria if the person is ineligible to obtain a shelter placement in Alexandria.

There are three local "soup kitchens" utilized by PATH consumers. Meade Memorial Church and Salvation Army provide a bag lunch six days per week. Christ House provides dinner seven days per week.

Local church organizations have taken an active approach to assisting PATH consumers. Christ Church, Old Presbyterian Meeting House and Alfred Street Baptist Church are the few among many that provide emergency financial assistance, food and clothing assistance to PATH and non-PATH consumers. Non-secular organizations, such as ALIVE! Inc., and Office of Community Services, associated with the Department of Human Services, provides emergency financial assistance.

The Homeless Services Coordinator has established a close working relationship with local provider networks in assisting PATH and non-PATH consumers (outreach only) to reach their optimal level of functioning within a community setting. Local service providers do not limit their services to only those homeless individuals who are seriously mentally ill, targeted only by PATH, but engage a wider constituency of the homeless population. All of the above service providers are utilized by PATH consumers, either as a direct referral by the Homeless Services Coordinator or by word of mouth within the homeless community network.

Concurrently, staff of the aforementioned local organizations makes referrals to the Homeless Services Coordinator for possible PATH consumers.

David's Place is a PATH-funded drop-in center that was established in 1993 in collaboration between Alexandria Mental Health and Carpenter's Shelter. Exclusively the shelter now operates it. PATH consumers in search of a place to take a shower or wash clothes, or who otherwise need a safe haven from the streets frequent David's Place.

**d**. Gaps in the current service system:
Although there appears to be an adequate number of emergency shelter beds in Alexandria, difficulties arise in accommodating the mixture of the homeless population. Problems accommodating homeless persons seeking shelter include the ability to house families, single men and women within the same facility because a specific number of beds are set aside for certain groups. This problem is exacerbated by the difficulty shelters have managing non-compliant individuals or those individuals who exhibit bizarre or odd behaviors. An emergency shelter is needed that would specialize in providing shelter to those individuals that, by virtue of their illness (such as schizophrenia with paranoid features) cannot or will not utilize the existing shelter systems. Trained mental health workers familiar with the symptoms of psychosis and able to be pro-active in addressing the issues would staff the emergency shelter. There are certain barrier

crimes, such as arson or sexual offenses that make it impossible to utilize existing shelter beds or longer-term residential services within the City of Alexandria. A referral could be made to a shelter outside the City of Alexandria. This referral would include all pertinent information necessary to make the referral, including assessment of risk. Before making the referral, the PATH consumer would be required to sign consent to release information to any outside organization.

There is an overall lack of affordable housing within The City of Alexandria for PATH and non-PATH consumers. The PATH consumer is in competition with the general population for safe and affordable housing. However, the PATH consumer is at a great disadvantage, falling into the extremely low or low-income level. The waiting lists for subsidized housing opportunities are between three to four years long.

The lack of opportunities for health and dental care is a problem encountered by PATH consumers, who lack entitlements such as Medicaid, Medicare or other medical insurance that accompanies Supplemental Security Income, Social Security Disability Insurance, or full time employment.

Casey Clinic provides medical care to low- income Alexandria residents but the consumer must present with a chronic ailment, such as diabetes, severe and persistent hypertension and HIV/AIDS.

The Alexandria Health Department Dental Clinic assists low-income individuals but only performs extractions. The Northern Virginia Dental Clinic and Donated Dental Services Project, in conjunction with the Virginia Dental Association, provide assistance to PATH and non-PATH consumers with a variety of services. However, the waiting period for these services can be three months to one year.

The Homeless Services Coordinator has been able to utilize a network of agencies and non-profit organizations to advocate for the needs of PATH consumers who may have otherwise fallen through the cracks in the system. This network is in a constant state of reorganization and development.

It is not surprising that many homeless individuals lose their identification cards, birth certificates or other documents establishing their identity. A major barrier the homeless population encounters is obtaining a valid identification card. The Department of Motor Vehicles (DMV) has undergone several policy changes as a result of the terrorist attack on September 11, 2001. DMV requires two identification documents, one proof of “legal presence”, (meaning the person has a legal right to be in the United States) and one proof of Virginia residency. Without identification, a person cannot apply for benefits, employment or gain access to mainstream services.

Access to mainstream services is a priority with the SMI, chronic homeless population. However, if a PATH consumer agrees to accept services, he/she still must endure a 2-4 week wait for a CSB clinical intake. After that intake is complete, there is a 4-week wait

for a first-visit to the psychiatrist. Psychological testing may be recommended for a more definitive diagnosis but the wait will be an additional 2 months and perhaps longer. The wait list for individual therapy can be between 1 – 4 weeks, if the unit is fully staffed. If not fully staffed, the wait can be 8 – 12 weeks.

**e.** Services available for clients with co-occurring mental illness and substance use disorders:
The Homeless Services Coordinator has been cross-trained so as to be knowledgeable and conversant with diagnoses, treatment, and services in the areas of both mental illness and substance abuse. The Homeless Services Coordinator conducts assessments for both disorders and makes the appropriate recommendations. Assessments include mental status, risk to self and others, urine screens for drugs, and an overall behavioral assessment based upon contact with the individual as well as any information that might be acquired through other sources. Initial recommendations could include Social Detox through the Board's Substance Abuse Services, a direct shelter referral, or perhaps, in an acute crisis situation, a recommendation for psychiatric hospitalization or medical detoxification. The Homeless Services Coordinator operates within the Alexandria Mental Health Center but works closely with staff from the Substance Abuse Services to provide a multi-disciplinary team approach to address the varying needs of consumers with a mental illness and co-occurring substance abuse disorder.

**f.** The Alexandria Community Service Board's PATH funds do not specifically provide for housing services. The Homeless Services Coordinator makes referrals and advocates for PATH consumers for residential programs affiliated with the Alexandria Community Services Board. Programs include:
Columbus and Wythe: Established in 1994, this facility can house a total of seven residents with one live-in staff person. Provides permanent/supportive housing to consumers with a mental illness and co-occurring substance abuse disorder. Must be homeless prior to admission.
North Howard Street: One-year transitional housing program. Provides opportunity for homeless consumers to improve daily living skills, develop a sense of security and safety, and have a structured environment with which to develop or improve interpersonal skills. Serves PATH and non-PATH consumers.
Aspen House: Two-year transitional housing program, with a capacity for four consumers, all of who are homeless and have a mental illness and co-occurring substance abuse disorder.
Mayflower and Canterbury Square: Supervises residents of four condominiums in permanent supportive housing. This program has a capacity of eight consumers, all of whom were homeless prior to moving into the homes.
Family Housing: Supervises residents in three condominiums that provide permanent supportive housing for adults with mental illness and who are accompanied by their children. The families must be homeless to qualify for the program.
Supervised Apartments / Notabene: Permanent supportive housing to ten consumers with a chronic mental illness. Must be homeless or in transitional housing program prior to admission to the program.

With the exception of North Howard Street, all of the above residential programs require the consumer to be homeless prior to admission into the program. However, the ACSB has a wide range of housing options that do not require the individual be homeless. The PATH consumer would be eligible for these services as well.

As member of the residential screening committee, the Homeless Services Coordinator actively participates not only in the referral process but also the screening of all referrals made to the Community Services Board residential program.

The Homeless Services Coordinator makes referrals, assists with applications and advocates for PATH consumers with subsidized housing programs. The PATH consumer would be assessed for all suitable housing opportunities and referrals would be made to one or more options at the appropriate time. Referrals are made to the Board's residential services or to several housing resources (transitional and permanent / supportive) throughout the City of Alexandria. These resources include Fox Chase and Olde Towne West, apartment complexes in Alexandria with project-based Section 8. The Alexandria Redevelopment and Housing Authority (ARHA) maintain the public housing and Section 8 waiting lists. Waiting lists are approximately 3-4 years.

Arlington / Alexandria Coalition for the Homeless, Community Lodgings, and Salvation Army Cornerstones Program sponsor transitional housing programs for homeless families. Northern Virginia Family Services and Carpenter's Shelter sponsor transitional housing for families and individuals. PATH consumers are eligible for the above services. However, many are screened out due to the severity of their illnesses.

**4. <u>Coordination with HUD Continuum of Care Plans:</u>**

The Homeless Services Coordinator and other staff from the Alexandria Community Services Board are active members in the Alexandria Homeless Services Coordinating Committee (HSCC). The HSCC had direct input into the Continuum of Care that has been incorporated into the Alexandria Consolidated Plan July 1, 2000 - June 30, 2005. A staff member of the Alexandria Community Services Board is a major author of the Continuum of Care.

As a result of a comprehensive gaps analysis of resources for the homeless, SMI population, The City of Alexandria's Continuum of Care / Consolidated Plan identifies three specific objectives related to the PATH consumer.

- Develop an eight to twelve bed facility, or allocate those beds within an existing facility, for the chronically homeless, SMI consumer. This facility is typically called a Safe Haven and has been identified as the number one priority of the HSCC. The CSB has identified the Safe Haven as the number one board goal as well.
- Identify additional public or private resources to add 1.5 FTE mental health / substance abuse counselors to provide evening and weekend outreach.

- Develop resources to provide transitional housing and comprehensive support services to an additional 131 individuals and 58 families who are homeless or at risk for homelessness.

**5. Cultural Competence:**

The Alexandria Community Service Board's racial/ethnic profile is as follows:

| Race/Ethnicity of CSB Staff | Org. Staff % | Service Area % |
|---|---|---|
| American Indian or Alaskan Native | 0 | 0 |
| Asian | 4 | 6 |
| Black or African American | 54 | 24 |
| Hispanic or Latino | 6 | (15) of total |
| Native Hawaiian or other Pacific Islander | 0 | 0 |
| White | 37 | 62 |
| Other | 2 | 8 |

The identified PATH staff is white.

The Community Services Board has made Cultural Competence and Boundary trainings mandatory. These trainings occur within the first weeks of hiring and must be completed prior to client contact. Confidentiality, Human Rights and Ethics trainings are also mandatory and must be completed yearly.

The City of Alexandria has a culturally diverse population. Accordingly, the homeless population is equally diverse. The Homeless Services Coordinator utilizes existing staff resources to accommodate the various languages spoken by consumers or potential PATH consumers. However, if existing staff is unable to accommodate this need, the Alexandria Language Bank will be available.

The CSB provides copies of the Consumer Handbook, Verification of Consumer Orientation and Notice of Charges in Spanish.

**6. Consumer and Family Involvement:**

Homeless consumers and families are encouraged to participate at every level within the CSB. During the City Budget Public Hearing in November 2003, three former PATH consumers testified before City Council and spoke about the need for a Safe Haven. Each had been a PATH consumer within the year but had "graduated" from the program upon securing CSB sponsored housing. Family members of CSB consumers, as well as concerned City residents, wrote over 100 letters to City Council, the Mayor and City Manager in support of the Safe Haven.

An Individual Service Plan (ISP) is developed when the PATH consumer agrees to accept mental health services. The ISP is reflective of a thorough needs assessment completed at the CSB intake. The ISP identifies specific problems related to mental illness and homeless status but could include issues related to substance use, medical problems or other conditions the consumer deems appropriate for intervention and service. Goals are established for each problem and

objectives and strategies identified that will enable the consumer to meet the identified goal. Changes are made to the ISP indicating the varying needs of the consumer with the appropriate documentation. Signatures are required on the ISP by the PATH consumer as well as all members of the treatment team.

The PATH consumer and treatment team review the ISP quarterly and chart the progress. The treatment team and consumer review the ISP annually. By the time of the annual review of the ISP, the PATH consumer has usually moved to mainstream services and the ISP would have already been amended.

Family members are encouraged to participate in the consumer's treatment. While most are not prepared to provide housing to the PATH recipient, emotional support is important.

Alexandria Community Services Board (FFY04)

| Category | | | PATH Funded Amount | Non-Federal Direct Match | Source of Match Cash or In-Kind *( delete one)* |
|---|---|---|---|---|---|
| **Staff Title** | **Annual Salary** | **FTE** | | | |
| *Therapist III* | [redacted] | *1.0* | [redacted] | [redacted] | *Cash* |
| | | | | | Cash / In-Kind |
| **TOTAL PERSONNEL** | | | [redacted] | [redacted] | Cash |
| **TOTAL FRINGE BENEFITS** | | | [redacted] | [redacted] | Cash |
| **Travel** *e.g.: Outreach, or travel to training, or travel to state meetings* | | | | | |
| Outreach; travel to state meetings and trainings | | | [redacted] | [redacted] | Cash |
| Training | | | [redacted] | [redacted] | Cash |
| | | | $ | $ | Cash |
| **Equipment List** *individually any non-expendable, tangible personal property having a useful life of more than one year.* | | | | | |
| | | | $ | $ | Cash / In-Kind |
| **Supplies** *e.g.: Program Supplies or Computer Software* | | | | | |
| Program Supplies | | | [redacted] | [redacted] | Cash |
| Emergency housing and one time rental assistance | | | [redacted] | [redacted] | Cash |
| Bus tokens / rail passes | | | [redacted] | [redacted] | Cash |
| **Contractual** *If more contracted services, attach an additional sheet with description.* | | | | | |
| Non-Program Administration | | | $ | [redacted] | Cash |
| | | | $ | [redacted] | Cash / In-Kind |
| **Other** *Describe any other proposed expenditures* | | | | | |
| Drug screens and medications | | | [redacted] | [redacted] | Cash |
| Office space and building maintenance | | | [redacted] | [redacted] | Cash |
| | | | **PATH** | **Match** | |
| **Total PATH Budget** | | | $50,327 | $59,712 | |

| 1. Program Information | |
|---|---|
| **PATH-Funded Organization** | **Blue Ridge Behavioral Healthcare** |
| **Organization Description** | Blue Ridge Behavioral Healthcare is a Community Services Board providing publicly funded Mental Health, Mental Retardation and Substance Abuse services to the citizens of the cities of Roanoke and Salem and the counties of Botetourt, Craig, and Roanoke. |

**2. Federal Path funds for 2004: $42,576**

**Budget Narrative:**

***Personnel Costs –*** BRBH PATH employs an Outreach Worker (.50 FTE) who visits shelters, parks and other areas frequented by homeless individuals, and takes referrals from the local Homeless Assistance Team and shelter staff, in order to make contact with individuals suspected as having problems related to mental illness. This worker establishes contact, builds a relationship, and then attempts to engage the individual in community services and supports, facilitating intakes, the identification of housing options, and the application processes for access to community resources. The outreach worker receives a small amount of clerical support from a secretary (.10 FTE).

***Vehicle Operating Costs, User Fees, Personal Mileage*** – This total represents [redacted]% of the annual agency user fee for the van available for PATH Outreach activities, $[redacted] in annual vehicle operating costs, and $[redacted] for personal mileage reimbursements incurred when the agency vehicle is not available.

***Program Supplies –*** Office supplies, personal hygiene and maintenance materials, vehicle maintenance materials and other expendable items used in day-to-day operations.

***Hygiene Kits –*** Personal hygiene materials (soap, toothbrush, toothpaste, razors, etc.) and other items packaged in individual packs for distribution to homeless individuals.

***One-Time Rental Assistance –*** Rent paid for consumers in order to prevent eviction.

***Vehicle Maintenance -*** Maintenance costs associated with van operations.

***Telephone Services –*** Desk and cellular phone service charges.

***Required Match***

$14,192 in matching funds will be made available from Virginia General Funds available to Blue Ridge Behavioral Healthcare. BRBH hereby provides assurance that the match required for this PATH project and detailed in the budget attached will be available on July 1, 2004, the start date for this project.

**3. Services Plan**

| | |
|---|---|
| **a. Projected Number to be served with Federal funds in FFY 2004:** | 218<br>It is expected that upwards of 95% of these individuals will be living outdoors or in emergency shelters as PATH services are provided. |

**b. Specific Services to be provided:**

Blue Ridge Behavioral Healthcare PATH will provide the following services:

1. intensive outreach
2. screening/diagnostic services related to mental health and substance abuse service needs
3. referrals to mental health services (e.g. Psychiatric services, medication management, case management, rehabilitative services), substance abuse treatment (e.g. assessment, detoxification, counseling, education and therapeutic residential services) and other local support services
4. case management until engaged with mental health services
5. housing services including planning, technical assistance, one-time rental assistance, and the coordination of housing and other services
6. distribution of hygiene packs where appropriate

**c. Community Organizations Providing Key Services:**

| | |
|---|---|
| Health and Medical Services | Rescue Mission Health Center |
| | Kuumba Medical Center |
| | Free Clinic of the Roanoke Valley |
| Mental Health Care | Blue Ridge Behavioral Healthcare |
| | Family Services of the Roanoke Valley |
| | Mental Health Association Consortium |
| | Kuumba Medical Center |
| Substance Abuse Services | Blue Ridge Behavioral Healthcare |
| | Mount Regis Center |
| | Rescue Mission of the Roanoke Valley |
| | Lewis Gale Pavilion |
| | VAMC Salem |
| Housing Services | Rescue Mission of the Roanoke Valley |
| | TRUST Shelter and Transitional Living Program |
| | Salvation Army Sanctuary |
| | Salvation Army Red Shield Lodge |
| | VAMC Salem Fire Base Hope |
| | TLC Transitional Living Center |
| | YWCA Transitional Living Program |
| | TAP Housing SRO Program |
| | Roanoke City Shelter Plus Care |
| | Roanoke Redevelopment and Housing Authority |
| Employment Services | Virginia Employment Commission |
| | TAP This Valley Works Program |
| | Goodwill Industries of the Valley |
| | Hired Hands Supported Employment Services |
| | RSVP Employment Services |
| | Mountain House Clubhouse |

Services in support of the Homeless are planned and coordinated at three levels in the Roanoke Valley – the Roanoke City Mayor's Task Force on Homelessness, the area Continuum of Care Committee, and the HELPS group (Homelessness programs Educating and Linking Providers of Service), a group of direct service providers organized by the Roanoke Valley Task Force. The vast majority of these community organizations are represented at one ore more of these coordinating groups. Relationships built in carrying out the work of these three groups provide a greater understanding of the intake process, eligibility requirements and the capability of the various resources to provide assistance. In addition, working together can provide a personal contact that often proves invaluable in securing access, problem solving and the provision of successful supports for the individual who is homeless and in need. While the PATH Outreach Worker may have little impact in accessing these resources as a relationship is built, an effort is made to be of assistance where assistance is accepted. Beyond that, a developing system of Case Management at various shelters and agencies insures that access to appropriate resources is a priority, and these staff benefit from information provided by the PATH staff as supports are put into place.

**d. Gaps in the Current Service System:**

Noted gaps in housing services include:

- limited access to safe, affordable housing (and funding for required supports)
- an extensive waiting list for Section 8 vouchers
- problems with expedient access to the Shelter Plus Care program
- no Safe Haven program for individuals currently intolerant of program rules regarding participation in treatment
- safe SRO options
- and housing that is accessible for people with physical limitations.

Other access problems include:

- delays in securing appointments for intake and assessment (often compounded by a wait for case management services and yet another delay in accessing appropriate supportive services)
- delays in eligibility determination for mainstream resources such as Social Security benefits, Medicare and Medicaid
- Medicaid eligibility requirements related to income that are too restrictive (with Medicaid the primary source of funds for necessary supportive services)
- limited access to psychiatric services
- lack of openings in the local detox programs
- and limited funds for prescription medicines.

**e. Strategies for providing services to clients with co-occurring mental illness and substance abuse disorders**

Homeless clients with dual disorders are offered detoxification and primary care coordinated with services to meet their mental health needs through the Department of

Prevention, Assessment and Counseling Services at BRBH or through the Veteran's Administration Medical Center. In addition, individuals not requiring that level of need are offered MICA groups available in conjunction with counseling, case management and psychiatric services through the Department of Community Support Services at BRBH.

**f. Strategies to provide suitable housing**

BRBH is working with a variety of agencies through the Continuum of Care process and other means to increase the stock of affordable housing and provide supportive services where appropriate. Specific projects being explored include:

- the development of a single-site SRO
- an additional number of beds in transitional housing
- securing additional Section 8 vouchers for people with disabilities
- the development of a Safe-Have program
- and a Section 811-funded project that would house people with mental illness who need permanent supportive housing.

PATH-eligible individuals will have housing services made available through a coordinated effort with the HAT team and the Continuum of Care agencies. Sponsors of these programs include:

1) TAP's Transitional Living Center, 23 24th Street, Roanoke.
2) Blue Ridge Housing Development Corporation, 510 11th Street, Roanoke.
3) TRUST, 408 Elm Ave, Roanoke
4) YWCA, 605 First Street, SW, Roanoke
5) Mental Health Support Services, BRBH, 1125 First Street, SW, Roanoke (supportive training and assistance available once engaged in agency services)

On an individual basis, Case Managers work with consumers in securing appropriate housing to meet their needs. With PATH funding for 2004, BRBH PATH will continue its efforts to locate appropriate, affordable housing, and use both PATH and local funds for one-time rental assistance to prevent homelessness. Housing is secured through several avenues: Roanoke Redevelopment and Housing Authority (Section 8 and Moderate Rehab), Roanoke City's Shelter Plus Care program (HUD) and Total Action Against Poverty's (TAP) Transitional Living Center and scattered-site SRO program (HUD). In addition, staff works with numerous private landlords to secure affordable housing.

**4. Coordination with HUD CoC:**

PATH-funded services are coordinated with local HUD Continuum of Care plans through the active involvement of PATH supervisory staff on the Continuum of Care Committee, and the Roanoke Task Force on Homelessness Committee. In addition, PATH staff involved with the HELPS Committee, a group of direct service staff who meet and discuss common concerns, barriers to service, and available resources. PATH staff also works closely with the Housing Assistance Team, an outreach team managed by the City of Roanoke and funded through the local CoC efforts.

**5. Cultural Competence:**

| BRBH Organizational Profile | Total | Relative Percentages | Community Profile |
|---|---|---|---|
| **Total Staff** | 390 | 78% Female/22% Male | |
| **White** | 286 | 73% | 85% |
| **African American** | 99 | 25% | 13% |
| **Hispanic** | 3 | 0.8% | 1% |
| **Asian** | 2 | 0.5% | 1% |

The Roanoke area has limited diversity in terms of cultural background, although, as in most areas of the U.S. this is changing. The PATH staff consists of one half-time FTE employee (white male with Hispanic ancestry) and one .10 FTE secretary (white female). Additionally, PATH staff include an individual who was at one time homeless. Attempts are made to provide PATH staff with cultural competency training at least once yearly, but limited opportunities in the region served makes this difficult. In addition, PATH staff consult with a representative of the Refugee and Immigration Services program in Roanoke; these contacts are typically for referral purposes, or for information on local immigration trends and resources. BRBH recognizes that cultural concerns, much like the concerns of the community of people who are different because of a disability, are an area of importance in dealing with the homeless population, and that it will be increasing in importance as the local population changes in the years to come.

**6. Consumer/Family Involvement**

Blue Ridge Behavioral Healthcare actively seeks input from family and consumers and maintains a family presence in the membership of its Board of Directors, as well as inviting consumer and family participation on various advisory boards and work groups that provideng input into program development and design, administration and evaluation. This includes family representation on the Mental Health Advisory Committee of the Board, the group which oversees the work of BRBH PATH. Informed consent is assured through agency policy and procedures, and the agency convenes the Local Human Rights Committee, the group that has oversight responsibility for the development and application of the Local Human Rights Plan. Individuals who have been enrolled in BRBH PATH and subsequently successfully engaged in appropriate treatment will be surveyed annually about their reactions to the PATH activities, their satisfaction with current services and housing, and recommendations for changes that they would like to share. Plans for the 2004 survey call for the addition of questions about the perceived value of a PATH Advisory Board and the respondents' willingness to participate on such a board. If sufficient interest is evident, then BRBH will convene a consumer-based advisory board to provide guidance on both program operations and the services provided after engagement in the local mental health system.

Budget – Blue Ridge FFY04

| Category | | | PATH Funded Amount | Non-Federal Direct Match | Source of Match Cash or In-Kind ( *delete one*) |
|---|---|---|---|---|---|
| **Staff Title** | **Annual Salary** | **FTE** | | | |
| ***e.g.: Outreach Staff*** | [redacted] | [redacted] | [redacted] | ***4,000*** | ***Cash*** |
| Outreach Worker | | | [redacted] | | |
| Secretary | | | [redacted] | | |
| | | | | | |
| | | | | | |
| | | | | | |
| **TOTAL PERSONNEL** | | | [redacted] | $ | |
| **TOTAL FRINGE BENEFITS** | | | [redacted] | $ | |

**Travel** *e.g.: Outreach, or travel to training, or travel to state meetings*

| | | | |
|---|---|---|---|
| Vehicle Operating Costs, User Fees, Personal Mileage | [redacted] | $ | |
| Travel to Training, Workshops, State Meetings | [redacted] | $ | |
| | | $ | |

**Equipment** *List individually any non-expendable, tangible personal property having a useful life of more than one year.*

| | | | |
|---|---|---|---|
| | $ | $ | |

**Supplies** *e.g.: Program Supplies or Computer Software*

| | | | |
|---|---|---|---|
| Program Supplies | [redacted] | [redacted] | Cash |
| Hygiene Kits | [redacted] | [redacted] | Cash |
| | $ | $ | |

**Contractual** *If more contracted services, attach an additional sheet with description.*

| | | | |
|---|---|---|---|
| | $ | $ | |

**Other** *Describe any other proposed expenditures*

| | | | |
|---|---|---|---|
| One-Time Rental Assistance | [redacted] | [redacted] | Cash |
| Vehicle Maintenance | [redacted] | | |
| Telephone Services | [redacted] | | |
| Non-Program Administration | [redacted] | [redacted] | Cash |
| | **PATH** | **Match** | |
| **Total PATH Budget** | $42,576 | $14,192 | |

Note: The PATH budget period runs from 9/1/04 through 8/31/05, even though the reporting period runs from 7/1/04 through 6/30/05. You will be paid from the current PATH budget for July and August 2004

1. **Provider Organization**

   - **Organization Name: Carpenter's Shelter**
   - **Type:** Carpenter's Shelter is a nonprofit agency that spans the continuum of care in Alexandria. PATH funds its David's Place drop-in day shelter serving the unsheltered homeless living on the streets of Alexandria, Virginia.
   - **Description of Services Provided by the Organization As a Whole:** *"Carpenter's is an innovative provider of services to the homeless promoting lifelong self-reliance."* As Northern Virginia's largest homeless shelter**,** Carpenter's serves more than 1,000 homeless or formerly homeless children, families and adults each year by coordinating five interrelated programs that span the continuum of care for all homeless individuals.
   - **Region Served:** Northern Virginia.

2. **PATH Funds**

   Carpenter's Shelter is requesting $35,504 in PATH funds, and the full budget can be found on page six. PATH funds will be used to fund [redacted] percent of the David's Place Program Director's salary and fringe benefits, totaling $[redacted]. $[redacted] will go to travel expenses, which are used to attend trainings, workshops and state meetings. Program supplies, including maintaining the computers and washing machines, as well as detergent for the machines and other programmatic supplies will be funded with $[redacted] of PATH funds. The telephone service for David's Place will also be funded with PATH funds in the amount of $[redacted]. Finally, $[redacted] will be used on client services, which include items such as metro cards and bus tokens, birth certificates, and food for clients.

3. **Services Plan**

   **A**. Projected number of clients to be served in FY 2005:

   We expect to serve 200 PATH eligible clients in FY2005. 100 % of these clients are "literally homeless", living outdoors or in emergency shelter.

   **B.** Specific services to be provided:

   David's Place is unique in the services it provides its members in Alexandria. It is a warm, safe respite from the streets where members can take care of their daily needs and access the showers, restroom facilities, laundry services, and secure storage areas, in addition to the services noted below.

   - Passive and active outreach
   - Screening and diagnostic treatment
   - Facilitate community mental health services
   - Facilitate alcohol and drug treatment for the dual diagnosis, MI/SA
   - Facilitate referrals for primary health services, job training, educational services (including HIV prevention) and relevant housing services.

**C.** Community organizations that provide key services and how we coordinate with these services.

**Christ Church** offers referrals to other agencies, assistance with transportation, clothing a limited amount of emergency funds, pastoral counseling and outreach. **Christ House** offers referrals to other agencies, a limited number of shelter beds for men, a daily dinner and some clothing. **ALIVE!** Offers referrals to other agencies, delivery of canned food and furniture to people who have recently found permanent housing and a limited amount of money for prescriptions for those who are homeless.

The **Old Presbyterian Meeting House** and **First Baptist Church** offer referrals to other agencies and a limited amount of money for prescriptions. **Meade Memorial Church** offers referrals to other agencies and serves lunch to the homeless Monday through Friday. The **Salvation Army Residential Program** offers referrals to other agencies, a six to twelve month residential work program to help residents save money in order to obtain housing, substance abuse counseling, counseling on issues relating to daily living, and a limited amount of vocational training.

**Alexandria Volunteer Bureau** provides volunteers for job mentoring, life skills and other special programs. **K & I Services** facilitates a monthly HIV/AIDS awareness seminar and offers individual counseling. **Joblink, Patrick Street Clubhouse** and **Laurie Mitchell Employment Center** regularly visit David's Place to explain their services and to conduct sessions on job preparation, job search skills, and employment options for the disabled and those with mental illnesses. They also provide assistance with transportation. Outreach workers from **Martinsburg, West Virginia Homeless Domiciliary Program** are on site on a weekly basis. Veterans are assisted with benefits, medical treatment, mental health, substance abuse treatment, housing, and transportation.

Alexandria Department of **Human Services** provides a representative to assist David's Place members with benefits and referrals. A volunteer substance abuse counselor and a representative from **Alexandria Substance Abuse Services** are available to counsel and provide referrals and treatment to clients. In addition, the shelter is part of a network of private organizations, which provide funding for prescriptions, transportation, clothing and furniture.

These agencies work together with Carpenter's to offer an opportunity for those who are homeless in Alexandria to receive a full continuum of services, treatment, and assistance.

**D.** Gaps in the current service system:

There still remains a woeful lack of low-cost, affordable housing in the City and permanent supportive housing for PATH clients. Affordable housing stock for those with marginal incomes are scarce and waiting lists to access these units are often years long. Emergency and transitional shelter beds for PATH consumers are also in short supply. There is no breakfast program for unsheltered PATH clients.

**E**. Services available for clients with co-occuring mental illness and substance use disorders:

Services for persons with co-occurring disorders are arranged by referral and linkage to the mental health and substance abuse programs of the Community Services Board of Alexandria and in Alcoholics Anonymous and Narcotics Anonymous meetings. David's Place provides homeless veterans assistance with obtaining necessary records and documents to access VA services through the hospitals in Washington, DC and Martinsburg, West Virginia and the Veterans Center in Fairfax County.

**F.** Stategies for making suitable housing available to PATH clients:

Suitable housing services are made available to PATH-eligible clients through referrals to various agencies. The Community Services Board in Alexandria has purchased dwellings for housing those with serious mental health illness and co-occurring disorders. The PATH funded Mental Health staff regularly informs shelter personnel of impending openings. Additionally, transitional housing through the Veterans Administration and the Salvation Army sometimes becomes available. Efforts are made to locate rooms for rent in private homes for PATH eligible individuals and if suitable, Mental Health/ Mental Retardation will refer an individual to the residents program. Apartment rentals in the private sector are rarely within the budgets of these individuals.

**4. Coordination with HUD Continuum of Care**

Carpenter's Shelter is an active participant with the City of Alexandria's Continuum of Care committee, known as the Homeless Services Coordinating Committee (HSCC). In addition, the Program Director of David's Place collaborates with City of Alexandria Continuum of Care providers as they address issues related to chronic homelessness, including mental health and substance abuse, as well as housing placement. Continuum of Care providers that Carpenter's partners with include: Alexandria Department of Human Services, Alexandria Community Services Board, Alexandria Public Health Services, Alexandria Department of Substance Abuse, The Salvation Army, Veteran's Administration, Public Health Department, as well as all of the churches mentioned in section three of this application. The CSB is in the process of applying for federal funds for a safe haven that PATH clients could utilize.

**5. Cultural Competence**

The Carpenter's Shelter staff is representative of the racial/ethnic diversity of the clients served. Of the nine case managers who work directly with clients, seven are African American, one is Latino, and one is Caucasian. Two case managers are bilingual. The case manager working directly with PATH eligible clients is an African American male, and the two weekend monitors are also African American, one female and one male. The racial breakdown for PATH eligible clients include 85% of African American, 14 % Caucasian and 1% Latino.

Sensitivity and respect for other cultures is a core Carpenter's Shelter value, and ongoing staff trainings address how to be cultural competent in tangible terms. Staff have put together an internal resource guide to services available in the community for

multicultural clients. David's Place rules and regulations are signed by each member at the time of intake and include a clause indicating that no member will be discriminated against because of race, gender, age, religion, racial/ethnic differences, or sexual preference.

**6. Consumer/Family Involvement**

David's Place holds bi-monthly members' meetings where clients can voice questions, concerns and suggestions with the staff. These meetings are open to everyone and participation is encouraged. Carpenter's conducts annual focus groups that involving consumers and Continuum of Care agencies. These discussions are intended to discover better ways that the community can serve unsheltered homeless individuals.

David's Place Program Director often coordinates with family members of PATH clients on matters of medical and general well-being needs. David's Place if often the link between a PATH client and his or her family, by acting as the venue for information exchange.

Carpenter's Shelter FFY04

| Category | | | PATH Funded Amount | Non-Federal Direct Match | Source of Match Cash or In-Kind *( delete one*) |
|---|---|---|---|---|---|
| **Staff Title** | **Annual Salary** | **FTE** | | | |
| Program Director | [redacted] | [redacted] | [redacted] | [redacted] | Cash |
| | | | | | Cash |
| **TOTAL PERSONNEL** | | | [redacted] | [redacted] | Cash |
| **TOTAL FRINGE BENEFITS** | | | [redacted] | [redacted] | Cash |
| **Travel** *e.g.: Outreach or Travel to State Meetings* | | | | | |
| Travel to trainings, workshops and state meetings | | | [redacted] | [redacted] | Cash |
| | | | $ | $ | Cash |
| **Equipment*** *List individually any non-expendable, tangible personal property having a useful life of more than one year.* | | | | | |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Supplies** *e.g.: Program Supplies or Computer Software* | | | | | |
| Program supplies | | | [redacted] | [redacted] | In-Kind |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Contractual*** *If more than one contracted service, attach an additional sheet with description.* | | | | | |
| | | | $ | $ | Cash / In-Kind |
| **Other** *Describe any other proposed expenditures* | | | | | |
| Telephone | | | [redacted] | [redacted] | Cash |
| Client Services | | | [redacted] | [redacted] | Cash |
| | | | **PATH** | **Match** | |
| **Total PATH Budget** | | | $35,504 | $11,842 | |

Budget Narrative: [redacted] of the PATH funding is going towards the salary of our only full-time staff member who extends outreach to PATH clients. The remaining [redacted] portion is used for travel, program supplies, telephone and client services. The non-Federal direct matching funds portion will be provided by community contributions.

1. **Provider Organization:**

**Central Virginia Community Services** (CVCSB)
The mission of CVCSB is to support and promote the health, independence, and self worth of individuals and families in Central Virginia by providing a continuum of community-based prevention, early intervention, treatment and aftercare services for persons affected by substance abuse, mental retardation, and mental illness.

CVCSB services the counties of Amherst, Appomattox, Bedford and Campbell and the cities of Lynchburg and Bedford.

2. **PATH:**
CVCSB will receive funding for FY 2005 to provide PATH services. PATH funds will be matched with agency funds by July 1, 2004 (see Appendix I for detailed PATH allocation and budget table).

3. **Services Plan:**
   a) Projected number of clients to be contacted is 240; projected number to be enrolled is 60. One hundred percent of the contacts are projected to be literally homeless.
   b) Services to be provided: Screening and diagnostic treatment, outreach, rehabilitation, community mental health services, alcohol and substance abuse treatment services, in-patient crisis stabilization, staff training, case management services, supportive and supervisory services in residential setting, job training, educational services, assistance in applying for housing, and referrals for primary health care services. Substance abuse treatment would be provided through referral to Arise Detox or Arise Treatment Center. Arise provides both residential and outpatient treatment programs as part of Central Virginia Community Services.
   c) Community Key Services: Local existing programs that could possibly provide services to PATH-eligible clients include:
      - Medical assistance is provided by the Lynchburg Health Department, the Free Clinic of Central Virginia, and the Johnson Health Center.
      - Mental Health services are provided by CVCSB, United Way of Central Virginia, and the Alliance for Families and Children.
      - Substance Abuse treatment is provided by Arise Substance Abuse Center, which is part of CVCSB.
      - Shelters: Miriam's House, Gateway, Hands Up Lodge, Salvation Army, Hope House, Network House, Present Help Ministries, and the YWCA women's shelter.
      - Food and clothing assistance is provided by Daily Bread, Salvation Army, and local churches.
      - Employment: Lynchburg Sheltered Industries, DRS and VEC.

   The PATH coordinator is responsible for referring and linking the homeless population to services in the community. The PATH coordinator also works with the homelessness to end homelessness and prevent it in the future. The PATH coordinator make referrals to all of the above resources and advocates for clients to receive appropriate assistance.

The PATH coordinator has an ongoing relationship with all of the above resources in the community.

d) Gaps: Due to limited resources, obtaining medication and substance abuse services for the mentally ill population is limited and sometimes inaccessible. There is limited space in shelters and many individuals are turned away. Homeless individuals are often turned down multiple times when applying for SSI. Appointments for doctor time at the above medical sites are limited due to funding and high need. Substance abuse treatment is limited due to funding and high demand for treatment. Many individuals are placed on a waiting list until a substance abuse bed becomes available.

e) Services available for clients with co-occurring mental disorders: These services are provided through Arise Counseling Center. Arise is a co-occurring treatment facility. Both mental health and substance abuse treatment issues will be addressed during treatment utilizing motivational interviewing techniques to engage clients in treatment.

f) Housing Strategies: The PATH coordinator is working to develop relationships with local landlords and housing agencies in order to help facilitate access to appropriate housing for PATH clients.

**4. Coordination with HUD Continuum of Care**

PATH funded services are coordinated with local HUD and Continuum of Care Plans through quarterly housing coalition meetings and outreach referrals to and from the local shelters. The PATH coordinator also makes bi-monthly contact with the food and clothing programs.

**5. Cultural Competence**

Demographic Information

| Category | Organization | Community |
|---|---|---|
| White | 74% | 80% |
| African American | 25% | 18% |
| Amer. Indian | 0% | 0% |
| Asian | <1% | 1% |
| Native Hawaiian | 0% | 0% |
| Other | <1% | 0% |
| Hispanic | <1% | 1% (of total) |

PATH staff member is white.

The PATH coordinator attends Cultural Diversity Trainings yearly. CVCSB has access to interpreters for non-English speaking clients. The trainings cover all issues of diversity such race, age and ethnicity.

**6. Consumer/Family Involvement**

PATH clients and their willing family members will be encouraged to submit recommendations for program planning and improvement

**Budget Form** Central Virginia CSB FFY04

| Category | | | PATH Funded Amount | Non-Federal Direct Match | Source of Match Cash or In-Kind *( delete one*) |
|---|---|---|---|---|---|
| **Staff Title** | **Annual Salary** | **FTE** | | | |
| Outreach Staff | [redacted] | [redacted] | [redacted] | | Cash |
| | | | | | Cash |
| **TOTAL PERSONNEL** | | | [redacted] | [redacted] | Cash |
| **TOTAL FRINGE BENEFITS** | | | [redacted] | [redacted] | Cash |
| **Travel** *e.g.: Outreach, or travel to training, or travel to state meetings* | | | | | |
| Training travel, meetings, conferences | | | $ | $ | Cash |
| | | | $ | $ | Cash |
| | | | $ | $ | Cash |
| **Equipment** *List individually any non-expendable, tangible personal property having a useful life of more than one year.* | | | | | |
| Car lease | | | [redacted] | $ | Cash |
| Personal items for clients | | | [redacted] | $ | Cash |
| | | | $ | $ | Cash |
| **Supplies** *e.g.: Program Supplies or Computer Software* | | | | | |
| Office supplies and administrative fees | | | [redacted] | [redacted] | Cash |
| Gas and maintenance | | | [redacted] | [redacted] | Cash |
| | | | $ | $ | Cash |
| **Contractual** *If more contracted services, attach an additional sheet with description.* | | | | | |
| | | | $ | $ | Cash |
| | | | $ | $ | Cash |
| **Other** *Describe any other proposed expenditures* | | | | | |
| **Training** | | | [redacted] | [redacted] | Cash |
| **Housing deposits and rental assistance** | | | [redacted] | [redacted] | Cash |
| | | | **PATH** | **Match** | |
| **Total PATH Budget** | | | $ 33,425 | $ 18,300 | |

Note: The PATH budget period runs from 9/1/04 through 8/31/05, even though the reporting period runs from 7/1/04 through 6/30/05.You will be paid from the current PATH budget for July and August

PATH INTENTED USE PLAN FISCAL YEAR 2004-2005

1) **Provider Organization**: **Arlington County CSB - Community Residences**, Homeless Case Management Program:
   - Description of Agency Services: Community Residences is a provider of disability services. Established in 1975, CR is a private non-profit organization that works in partnership with communities. We have developed a track record of providing innovative, quality services that meet the needs of each consumer. The agency is effective, responsive and flexible in meeting the needs of the communities where we provide services. The mission of the Community Residences is, "even more than independence: the promise of community". Community Residences provides persons with disabilities the opportunity to reach their highest potential. Dedicated professionals promote successful community living and work to enhance dignity, self-esteem and quality of life (www.comres.org)".
   - The Homeless Case Management Program: The Homeless Case Management Program (HCM) is a part of Community Residences and provides services to the mentally ill homeless population in Arlington County, Virginia. The HCM program provides a wide array of services to this population. HCM serves any person homeless or in danger of being homeless that has a mental health diagnosis. Persons are divided into three different categories within the HCM office. **Category one** - persons linked to Arlington, County Mental Health Services and have an Arlington, County Case Manager to help with service coordination, treatment planning, and housing opportunities. **Category two** – persons currently living on the street, illegally in a person's home, in hotels/boarding facilities, or in short term shelter. All of these persons are currently homeless and are not linked to mental health services offered by the County or another mental health provider. These persons are categorized as PATH eligible. They are eligible for HCM PATH services but have not completed an intake packet. Staff outreaches these persons frequently, setting goals to see them on a weekly basis. Persons are offered food, toiletries, clothing, referral information, and support from staff. The goal of this portion of the program is to link these persons to Community Residences, HCM services. **Category three**- PATH persons who have come to the HCM program and completed an intake packet. The PATH enrolled consumers are ones who want help accessing county/federal benefits, medical treatment, fair housing referrals, landlord/tenant help, assistance in utility bills, and accessing mental health services. PATH enrolled consumers are assigned a case manager from the HCM program and are offered assistance in obtaining, maintaining, and securing safe and affordable housing. Additional services like advocacy in benefits, mental health treatment, and funding for housing. PATH enrolled consumers do not have to link to mental health services if they chose not to do so. In addition, they do not have to move into housing if they chose but get food, toiletries, clothing, and medical referrals from the program.

   - **Region Served**: The HCM PATH program serves Arlington County, Virginia region.

**2) PATH Funds: $ 63,253 See Appendix 1 – Detailed PATH budget**

**3) Service Plan for PATH**

a) Projected number of clients who will receive PATH funded services for fiscal year 2005- The HCM program has served 131 consumers so far this fiscal year. 36 have been served in the PATH enrolled program, 95 were served in the so far in the PATH eligible program. The program expects to serve 95 (75% are projected to be literally homeless) persons in the fiscal year of 2005.

b) Description of specific services provided using full or partial federal PATH funds: CR uses PATH funds to provide outreach on the streets to individuals who are unable to access traditional services. Staff informs them of community resources and directly assists them with obtaining food, clothing, and shelter – ensuring their basic needs are met. Staff provides referrals to needed services; mental health, medical, substance abuse and/or food or drink. Staff also provides referrals to the HCM, transitional housing programs, support services, or the Safe Haven component of CR's services, as well as other agencies that best suit the consumer's needs and preferences. Funds are also used for consumer housing costs specific to application fees, security deposits, and first month's rent. Community Residences was one of the programs chosen for an increase in funding for Fiscal year 2005. The HCM PATH program will be able to increase staffing. This increase will help HCM hire another part time case manager and cover the increase in program management allocation. This increase in staffing will enable HCM to spend more time providing outreach and will increase access to the PATH program. In addition, the increase will provide staff with work cell phones to increase coordination of services in the field and more funding for mileage reimbursement to increase the time in the field. This increase will provide more funding for food and toiletries for the PATH population. HCM PATH is excited about the new opportunities this increase will give the program.

The goal of the HCM PATH Program is to provide funds and support to consumers who have a mental health diagnosis that are homeless or in danger of being homeless. These funds are distributed by providing food, clothing, toiletries, start up costs for housing, and emergency funding for rent, utilities, medical needs, food, eye/dental care and outreach supplies. To enroll in the HCM PATH program a person must:

a. Be homeless or in danger of being homeless.
b. Have a mental health diagnosis.

HCM PATH provides the following services:

- Outreach Services
- Screening for diagnostic treatment
- Community mental health referrals

- Alcohol and drug treatment referrals
- Weekly treatment centered groups on housing and mental health
- Staff trainings specific to the mentally ill PATH population
- Case management services
- Crisis intervention services
- Supportive services once a consumer moves into an apartment or room
- Referrals to medical clinics, employment services, job training, educational opportunities, and housing services/apartment buildings and/or landlords.
- Housing services including:
    a) Assistance in applying for housing
    b) Planning for housing
    c) Security deposits
    d) Application fees
    e) Start up funds for first month in housing
    f) Food
    g) Furniture
    h) Funds preventing eviction from current housing
    i) Utility funding
    j) Budgeting
    k) Payee acquisition
    l) Benefits acquisition including: food stamps, SSI, General relief and food bank referrals

c) Community coordination of services and the Homeless Case Management program: All service providers serving the SMI/homeless meet monthly at the Homeless Services Coordination Committee (HSCC). Tony Turnage, Director for Homeless Services in Arlington County, chairs the committee. He coordinates the development and implementation of the Continuum of Care plan in conjunction with committee members. In addition, the HCM staff participates in weekly treatment team meetings at the Arlington County Homeless Shelter to identify persons that are eligible for HCM PATH services.

d) Gaps in current services given by the HCM program: 1) Affordable housing is the biggest gap in our community. CR staff works with the community to educate the County Board on the need to increase subsides for affordable housing in the Arlington area. 2) Accessing support services for persons once in housing is another gap in services. Many persons once in housing need follow-up services to help them maintain the housing they have obtained housing. Though the county offers long-term supports these can take a long time to access. The HCM program will work with consumers until support services can be obtained though this can take up to three to six months. 3) Transitional housing for mentally ill homeless is another gap in services. The county currently offers transitional housing for persons working with Arlington County Mental Health services but there are no transitional housing services offered for the homeless not linked with Arlington County Mental Health.

e) Services offered by the Homeless Case Management Program that help persons with co-occurring mental illness and substance use disorders: HCM's homeless services specialize in meeting the needs of the homeless population with mental illness/co-occurring substance abuse. Upon meeting a consumer on the street, staff first meets the consumers basic need (food, clothing, financial assistance, and/or clothing). Many consumers are at first resistant, staff's first goal is to identify what the consumer needs most and try to help the consumer meet that need. During this time, staff is building a rapport with the consumer. If a substance abuse problem is identified in a PATH consumer, staff has usually developed enough of a rapport to offer referrals to substance abuse services. If the consumer is open to treatment, staff will link them to Arlington County Substance Abuse treatment, AA groups, and if the consumer is willing to commit to the long term recovery process, CR's SafeHaven program.

f) Strategies for making suitable housing available to PATH consumers: Community Residences, HCM program offers a 90-day transitional housing program for homeless consumers. A consumer is referred into this program once they are linked with mental health services offered by the county. CR offers other housing options to the mentally ill population such as the Community Residence's SafeHaven program, other group homes, and the Community Living Program (CLP), which offers long-term placements in both support services, and a townhouse program. Referrals to other agencies that offer provide suitable housing programs for housing, such as the Arlington County Milestones program are also offered.

**4) Coordination with HUD Continuum of Care:**

a. Coordination of services with other local PATH service providers: The HCM program works with other local providers on an ongoing basis. HCM works with Arlington Street Peoples Network (A-SPAN). HCM gets referrals from A-SPAN's winter shelter and meets with shelter residents while they are in the shelter. These contacts at the winter shelter have resulted many referrals appropriate to our PATH criteria. The HCM PATH program continues to get referrals to the Arlington County Domestic Violence Shelter, the Northern Virginia Mental Health Institute (NVMHI), and other service providers.

b. Arlington County local planning, coordination, and/or assessment activities: Community Residences HCM staff works closely with other HUD funded programs in the area. HCM referred 11 persons to the CR SafeHaven program and 4 consumers to the new HUD funded Milestones program in the County since the program opened its referral process in May 2004. Milestones offers apartments with support services already in place for consumers.

**5) Cultural Competence:**

a. Organizational profile of staff for race/ethnicity

| Category | Organization | Community |
|---|---|---|
| White | 47% | 72% |
| Black | 48% | 10% |

| | | |
|---|---|---|
| Amer. Indian | 1% | 0% |
| Asian | 4% | 9% |
| Native Hawaiian | 1% | 0% |
| Other | N/A | 9% |
| Hispanic | 1% | (18)% of total |

b. Race/ethnicity of the HCM PATH program: For fiscal year 2004, six Caucasian persons and four African Americans have been on staff. The staff has employed nine women and one man for fiscal year 2004. Three persons have been fluent in other languages and/or American Sign Language.
c. PATH services targeted to a cultural diverse population and their ability to be sensitive to age, gender, and racial/ethnical differences to clients: CR offers staff trainings on many culturally diverse subjects. Staff has also attended extensive trainings on human rights offered by Arlington County. HCM staff has attended trainings on fair housing issues specific to the mentally ill population. The HCM PATH staff has a staff member that works closely with the fair housing commission to ensure that persons are not discriminated because of gender, sexual orientation, physical/mental disabilities, and race. The HCM program has filed three fair housing complaints this year due to one or more of the above discriminations.
d. CR's ongoing trainings, in-services, and competency tests ensure staff is sensitive to racial/ethnic, age, gender, and other diversity issues. CR has mandatory trainings for staff on cultural diversity, life stage developmental milestones, recovery and empowerment for consumers, and human rights. CR measures performance by surveying consumers on the cultural sensitivity of staff. These surveys help CR and HCM understand the different race/ethnicity needs of all consumers.

E**xperience or track record of involvement with the target population:**
The HCM PATH Program continues to reach many of the Homeless in the Arlington County, Virginia area. Many of our referrals come from past consumers who refer friends/family to the program. Staff has represented three persons in fair housing claims this past fiscal year and continues to offer informal trainings to consumers about fair housing issues. During the past fiscal year staff has provided services to the Emergency Winter Shelter, the Domestic Violence Shelter and the Northern Virginia Mental Health Institute. Referrals from other Homeless shelters and community providers have increased; HCM-PATH is serving a diverse population of homeless consumers.

**Training and Staffing**:
Community Residence's provides many training that are specific to understanding cultural diversity and these trainings help ensure cultural competence. Staff participates in much training, not only offered by Community Residences but also by outside providers. Over the last fiscal year staff as participated in Community Residence's cultural diversity training and fair housing trainings for multi-cultural consumers. Multi-cultural discussion nights are offered by Community Residences and consumers and all staff are invited to attend.

**Language**:
The PATH program is serving a predominately English speaking population. The HCM program is able to access interpreters if needed to help the office service speakers of other languages. HCM keeps information on community resources, housing applications, social service applications, and other informational resources in English and Spanish. This helps consumers who speak both languages. Currently, the HCM staff offers interaction and American Sign Language for the Deaf and the hearing impaired. This service is new this year to the HCM-PATH program.

**Materials**:
HCM PATH currently collects information and gives materials to PATH consumers who speak Spanish. These materials are not developed by the program but are borrowed by many of the outside providers that the program works closely with. This information helps Spanish speakers access community resources.

**Evaluation**:
HCM PATH evaluates its program in a variety of ways. Consumer surveys have been developed by Community Residence's Clinical Management staff to give consumers an opportunity to discuss service delivery. A section of this survey deals with cultural diversity and sensitivity. Community Residences upon intake evaluates any special cultural, spiritual, or ethical needs through a questionnaire filled out by the consumer with their personal case manager. These needs are reflected in service plan development and delivery. In addition, Community Residences clinical management team evaluates cultural sensitivity and competence through materials developed by the management. In addition, CR uses the MHSIP, one of the indicators it measures is cultural sensitivity.

**Community Representation**:
Consumers from the PATH program have helped in all phases of the PATH program's design. PATH consumers have been part of the Board of Directors, hired as peer counselors, hired in other areas of employment including clinical and property management positions. In addition, PATH consumers have been a iatrical part in the past with consumer run services in the agency and continue to serve the agency

**Implementation**:
Arlington, VA is a diverse and vibrant area of Virginia. Community Residence's PATH office sits right between two of the most populated areas of the County, the Ballston and Claridon areas. This location helps our consumers easily find and access our services. PATH staff continues to outreach to the diverse neighborhoods of Arlington, County and is able to access other community resources (such as Arlington Street People's Network) and cultural agencies (such as Hispanic Committee) for interpreters, multi-language materials, and other items necessary to outreach to a diverse community. Community Residences sits on committees with other providers of homeless services in the County. This gives CR staff the knowledge of available resources specific to the homeless population.

6) **Consumer/Family Involvement**:
   a. Description of how homeless consumers and their families are involved with Community Residences in terms of planning, implementation, and evaluation or agency wide and PATH funded services: The consumer is the prime participant

in service planning. All service plans are completed and signed with the consumer. Staff encourages families and friends to participate in treatment. CR offers a variety of educational groups, support forums, and advocacy groups which all consumers, family, relatives, and friends are encouraged to participate. HCM also asks the consumer during intake if they are in contact with the family and offers individual consumer's families educational materials, groups, and supports to help the consumer's family or friends understand the consumer's concerns, diagnosis, and/or benefits.

Community Residences (CR) HCM program works as closely as possible with PATH consumers and their families. Community Residences offers PATH consumers the opportunity to connect with their families and offers families the many resources needed to help their family member. Community Residences works to involve consumer's families in the following ways:

**Agency Mission**:

Community Residences mission is as follows: " Even more than independence: the promise of community. Community Residences provides persons with disabilities the opportunity to reach their highest potential. Dedicated professionals promote successful community living and work to enhance dignity, self-esteem and quality of life (www.comres.org)".

**Program Planning**:

Community Residence's has family members and consumers involved in the planning of programs. Community Residence's always as a minimum of one family member and one consumer on the Board of Directors. CR also has a policy of hiring consumers into staff positions and uses our Consumer Advisory Board as a mechanism to receive feedback and direction on issues pertaining to CR. Consumer's who are hired into staff positions receive the same salary, benefits, training, and clinical support as any person working in that Community Residences position.

**Training and Staffing**:

Arlington Homeless Case Management Program Training Plan

<u>On Date of Hire</u>

- Agency Orientation (Inc: Human Rights [re-certify annually], Fire Safety [re-certify annually], Emergency Preparedness [re-certify annually], Infection Control [re-certify annually])

<u>Within 30 Days of Hire</u>

- CPR (re-certify annually)
- First Aid (re-certify every 3 years)

<u>Within 90 Days of Hire</u>

- Mandt (Day 1 only)
- Developmental Stages (Self Study/Exam)

<u>Within 180 Days of Hire</u>

- Violence Prevention for Community Workers
- Recovery & Empowerment
- Cultural Diversity

**Informed Consent**:
All consumers enrolled in the PATH program are given policies that are reviewed by staff during the enrollment process. Consumers' deicide on the policies they feel will most benefit them while enrolled in the program. These policies include: Consumer Rights Policy, Consumer Grievance Policy, Abuse and Neglect Policy, HIPPA regulations and consent, and releases of information for any party a PATH staff may need to contact while working with the consumer. No consumer at any time is required to sign a policy to enroll in the program.

**Rights Protection**:
Consumers are given the CR policy on Human Rights and HIPPA regulations during enrollment. Staff reviews these policies in depth with consumers allowing them informed consent when signing policies on Human Rights and HIPPA regulations.

P**rogram Administration, Governance, and Policy Determination**:
Consumers and their families are offered opportunities to sit on the Corporate Board of Directors. CR policy indicates the Board of Directors must have a minimum of one consumer and one family member at all times. Consumers and their families are also offered opportunities to participate in the Consumer Advisory Committee, and other committees in the agency. As a non-profit agency, committee members volunteer. Community Residences also has a Chairman's Counsel that recognizes consumer families and community members that provide support for CR.

**Program Evaluation**:
CR involves family and consumer whenever possible through education, facilitation in communication, and active participation in service planning. In addition, community residences measures program effectiveness by incorporating family and consumer participation in developing measurement tools. The Consumer Advisory Board spearheaded the effort to develop the consumer satisfaction surveys. These surveys are currently used by the agency as the instrument to measure program success. Consumers and their families review the survey on a regular basis. In addition, Community Residences policy states the agency cannot do research.

## **Budget Form** Community Residences' PATH Application for FFY04 / SFY05

| Category | | | PATH Funded Amount | Non-Federal Direct Match | Source of Match Cash or In-Kind *( delete one)* |
|---|---|---|---|---|---|
| **Staff Title** | **Annual Salary** | **FTE** | | | |
| *e.g.: Outreach Staff* | [redacted] | [redacted] | [redacted] | [redacted] | *Cash* |
| | | | | | Cash / In-Kind |
| Case Manager | [redacted] | [redacted] | [redacted] | | Cash / In-Kind |
| Case Manager | [redacted] | [redacted] | [redacted] | | Cash / In-Kind |
| Program Manager | [redacted] | [redacted] | [redacted] | | Cash / In-Kind |
| Clinical Coordinator | [redacted] | [redacted] | | [redacted] | Cash |
| **TOTAL PERSONNEL** | | | [redacted] | [redacted] | Cash |
| **TOTAL FRINGE BENEFITS** | | | [redacted] | [redacted] | Cash |
| **Travel** *e.g.: Outreach, or travel to training, or travel to state meetings* | | | | | |
| Mileage Reimbursement | | | [redacted] | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Equipment** *List individually any non-expendable, tangible personal property having a useful life of more than one year.* | | | | | |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Supplies** *e.g.: Program Supplies or Computer Software* | | | | | |
| Food supplies for outreach efforts | | | $ | $ [redacted] | Cash |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Contractual** *If more contracted services, attach an additional sheet with description.* | | | | | |
| Cell phones – 2 @ $45 per month | | | $ | $ [redacted] | Cash |
| | | | $ | $ | Cash / In-Kind |
| **Other** *Describe any other proposed expenditures* | | | | | |
| **Consumer Start-up & Outreach Funds** | | | $ | [redacted] | Cash |
| **Indirect Support Services – G&A** | | | $ | [redacted] | Cash |
| | | | **PATH** | **Match** | |
| **Total PATH Budget** | | | $ 63,253 | $ 21,085 | |

Note: The PATH budget period runs from 9/1/04 through 8/31/05, even though the reporting period runs from 7/1/04 through 6/30/05.
You will be paid from the current PATH budget for July and August 2004.

**FFY2004 / SFY 2005 PATH PROPOSAL**

1. **Provider Organization**

**District 19 Community Services Board**

A public non-profit mental health, mental retardation and substance abuse service agency.

Planning District 19 Localities:
Petersburg, Colonial Heights, Dinwiddie, Emporia/Greensville, Hopewell, Prince George, Surry and Sussex

2. **PATH Funds**

With regards to budget details, outreach includes monies for outreach consumers including the purchase of survival kits, sodas, lunches and bus tickets (both local and long distance). Travel includes costs associated with traveling to outreach opportunities, training workshops and state meetings. Equipment will include a cell phone and service. Program supplies are office supplies and furniture, backpacks. Computer software that is necessary to accurately capture program statistics and related homeless services websites. Auto maintenance is necessary to keep the PATH vehicle in a state of readiness. Other (housing) monies are used for one time rental assistance, such as deposits for the prevention of eviction and emergency utilities. The source of our local match will be agency funds and will be available on July 1, 2004. The amount of PATH funds is $38,904 and the match is $12, 968.

3. **Services Plan**

3a. 118 clients are projected to receive PATH funded services in FY 2005. 75% of these clients are projected to be "literally homeless".

3b. Specific services to be provided include:

- Outreach
- Staff Training
- Case Management
- Referrals for Primary Health Services, Job Training, Educational Services, and Relevant Housing Services
- Rental Assistance and Housing Deposits
- Screening
- Habilitation & Rehabilitation
- Alcohol & Drug Treatment (referral service)
- Supportive and Supervisory Services in Residential Settings
- Planning for Housing
- Technical Assistance in Applying for Housing Assistance
- Security Deposits
- Cost of Matching Individuals with Appropriate Housing
- One Time Rental Payment to Prevent Eviction

The PATH Case Manager provides non-traditional outreach and case management survives . Contacts are sought in the identified areas where street people are commonly found: abandoned buildings and cars, under bridges, near railroad trestles and shelters. The identified homeless person is then "walked through" the benefits acquisitions process by the provision of assistance gathering and filling out forms and taking the person for appointments. Local properties are inspected by the case manager and then these housing resources provided to the person. When necessary, the PATH Case Manager will provide the person with deposit funds to assist with the transition from homelessness. Along this process, assessment for additional needs is done both at the time of intake and on an ongoing basis with appropriate referrals to needed services (such as health care and substance abuse services)made. Finally, the PATH Case Manager conducts 2 yearly trainings at the local homeless shelter on the topic "Working with the Homeless Mentally Ill in a Shelter Setting".

3c. Organizations that provide services:

Hopewell, Emporia, and Petersburg Department of Social Services
Dinwiddie Department of Social Services
Petersburg Health Department
Petersburg Police Department
Department of Motor Vehicles (identification cards)
Downtown Churches United (feeding program)
Southside United Way
United Methodist Church of Colonial Heights (quilts)
Social Security Administration (entitlements)
McGuire Veterans Homeless Program
Saint Joseph Catholic Church Outreach
CARES
Salvation Army
Salvation Army Emergency Shelter
Petersburg Housing Authority
Hopewell Housing Authority
Tri-Cities Garden Villa

The majority of the organizations listed above comprise the “continuum of care” for homeless services for the District 19 area. Coordination amongst this group is organized in part at regular monthly continuum meetings. PATH participates in this coordination via attendance at these meeting as well as referrals and phone calls to the different agencies.

3d. Gaps in Services

Overall, with the passage of time, the ability of PATH to serve homeless consumers in our region has improved. As PATH has become more firmly grounded in the community, its outreach to both the homeless and to services and providers has expanded. Still several gaps in services exist. The most significant factor impacting our ability to serve the homeless stems from an increase in demand over existing available substance abuse services. The dually diagnosed population has increased along with waiting lists for services.

Additional factors affecting homelessness is the high rate of unemployment found in this area. There is 18% unemployment in Petersburg. It is difficult for citizens to find work outside of the locality because there is no transportation to carry them to areas where jobs exist.

There is a lack of clean, safe, affordable housing in this area, despite city efforts to remedy this and to restore historic sections of Petersburg. Shelter space for single females is scarce.

Accessing non-emergency room medical services has become extremely difficult. For a short time there was free medical care available in the city of Petersburg, but this has been curtailed. Services that were once available for the indigent have been pushed aside and are now delegated for those with insurance. Medical issues make it difficult to access shelters, adult homes and substance abuse treatment programs. The largest local hospital has recently announced that it is discontinuing its indigent medication program.

3e. Special needs for homeless clients with co-occurring disorders are being met through outreach, with referral for shelter, food, medication management, entitlements and permanent housing.

District 19 has hired a substance abuse therapist who is available to provide group and individual services to clients with co-occurring mental illnesses and substance abuse disorders.

3f. Strategies for making suitable housing available
The PATH Case Manager is a member of Southside Action Council, which meets monthly to address homeless issues. The PATH Case Manager now works closer with the landlords on issues of rent, and care of properties. D-19 has received housing choice vouchers from the Petersburg Redevelopment and Housing Authority. The PATH program is currently negotiating with a local motel to make available emergency temporary housing for those consumers who are temporarily homeless.

4. **Coordination with HUD CoC**
The District 19 PATH Program is a part of the continuum of care, which also includes numerous other area providers and meets as a body monthly. The PATH worker has served on the Shelter Advisory Sub-Committee and the Ranking Committee for Federal Funded Grants. Technical assistance is also provided to the United Way.

5. **Cultural Competence**
PATH staff, as well as District 19 staff, who may provide ancillary services to the homeless, have all participated in a two-day multi-cultural competency training. Other training is available to heighten staff sensitivity to cultural issues. These trainings are attended annually. D19 staff are considered to be representative of the racial/ethnic diversity of the clients served. The PATH worker has twenty years experience towards providing homeless services to the target population. An effort has been made to meet the

consumer in their environment through outreach attempts. The agency of which the PATH program is a part is comprised of 150 (60%) African-Americans, 98 (39%) whites and 2 (1%) Asians. The PATH Case Manager is Black. The community is comprised of 46% African American, 52% white, 1% Asian, and 1% other.

6. **Consumer/Family Involvement**

Consumer and family involvement is mandated by the performance contract that District 19 has with the Department of Mental Health, Substance Abuse and Mental Retardation Services. The Board of Directors of District 19 includes a consumer representative and a family member. The PACT (Program for Assertive Community Treatment) Team includes a consumer representative at its team meetings. District 19 is active with MESA family education groups. Consumers are encouraged to attend council meetings. The PATH Outreach Case Manager regularly attends Local Consumer Advocacy Committees (LCAC) meetings in each of our catchment localities. When a consumer is outreached, an attempt is made to contact and involve family members whenever possible. Peers have been utilized in overseeing particularly "hard to reach" consumers. District 19 Community Services Board has defined consumer's rights that are posted at each location. A yearly consumer survey evaluating the agencies services is distributed to consumers and their families.

**Budget Form** District 19 CSB FFY04 / SFY05

| Category | | | PATH Funded Amount | Non-Federal Direct Match | Source of Match Cash or In-Kind *( delete one)* |
|---|---|---|---|---|---|
| **Staff Title** | **Annual Salary** | **FTE** | | | |
| *e.g.: Outreach Staff* | [redacted] | [redacted] | [redacted] | [redacted] | *Cash* |
| Outreach CM | [redacted] | [redacted] | [redacted] | [redacted] | Cash |
| | | | | | Cash / In-Kind |
| | | | | | Cash / In-Kind |
| | | | | | Cash / In-Kind |
| | | | | | Cash / In-Kind |
| **TOTAL PERSONNEL** | | | [redacted] | [redacted] | Cash |
| **TOTAL FRINGE BENEFITS** | | | $ | $ | Cash / In-Kind |
| **Travel** *e.g.: Outreach, or travel to training, or travel to state meetings* | | | | | |
| Outreach | | | [redacted] | $ | Cash / In-Kind |
| Travel to Training, Workshops, State Meetings | | | [redacted] | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Equipment** *List individually any non-expendable, tangible personal property having a useful life of more than one year.* | | | | | |
| Cell Phone | | | [redacted] | [redacted] | In-Kind |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Supplies** *e.g.: Program Supplies or Computer Software* | | | | | |
| Program Supplies | | | [redacted] | [redacted] | In-Kind |
| Auto Maintinance | | | [redacted] | [redacted] | In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Contractual** *If more contracted services, attach an additional sheet with description.* | | | | | |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Other** *Describe any other proposed expenditures* | | | | | |
| One Time Rental Assistance | | | [redacted] | [redacted] | Cash |
| | | | $ | $ | Cash / In-Kind |
| | | | **PATH** | **Match** | |
| **Total PATH Budget** | | | $38,904 | $12,968 | |

Note: The PATH budget period runs from 9/1/04 through 8/31/05, even though the reporting period runs from 7/1/04 through 6/30/05.
You will be paid from the current PATH budget for July and August 2004.

*FFY 2004, SFY 2005 PATH Application: Local Provider Intended Use Plans*

1. **Provider Organization** Fairfax-Falls Church Community Services Board, serving the county of Fairfax and the cities of Fairfax and Falls Church. The Fairfax-Falls Church CSB provides referral, crisis intervention, case management, counseling, residential treatment, day treatment, detoxification, and medication services to those needing Mental Health, Substance Abuse and Mental Retardation services and residing within Fairfax County, Fairfax City, and Falls Church. The Fairfax-Falls Church CSB offers a wide range of outreach, outpatient, and residential services spanning all of the core services taxonomy areas placing an emphasis on providing evidenced based practices that incorporate consumer recovery involvement in the process.

   **PATH Funds** Anticipated PATH funds to be received are $154,597.00. As of July 1, 2004, a cash match of $51,532.33 will be available through Fairfax County general funds. See budget worksheet on page 11 for a detailed budget.
   Salary: Three full-time Outreach staff is requested to engage homeless consumers and provide them with treatment services. The [redacted] requested covers [redacted]% of staffs' salaries. The remaining [redacted]% ($[redacted]) will be a cash match from Fairfax County's general funds.
   Fringe Benefits: The fringe benefits requested at [redacted] covers [redacted]% of the cost to provide standard coverage for Fairfax County Government employees. The remaining [redacted]% ($[redacted]) will be a cash match from Fairfax County's general funds. Total fringe benefit costs are calculated by using the following rates:
   FICA: 7.65%
   Retirement: 6.04%
   Medical: 10.36%
   Life Insurance: 0.6%
   Unemployment Insurance: 0.75%
   Workman's Compensation: 0.2%
   Travel: Funding at $[redacted] is requested to cover partial costs for use of County vehicles, including fuel, vehicle replacement fund, and maintenance and repair. In addition, funding may be used to reimburse staff for mileage on occasions when privately-owned vehicles are used for travel. A cash match of $[redacted] will come from Fairfax County's general fund.

2. **Services Plan**:
   a. projected number of clients who will receive PATH funded services
      FY 2004 Total enrolled was 535. For FY 2005 93% of the clients the PATH workers serve are projected to be "literally homeless."

   b. List and describe how specific services are to be provided

- Outreach: Provided by PATH workers through drop in centers, physically performing outreach in the streets, faith based drop-ins, and outreach to wooded areas and other areas not meant for human habitation.
- Screening and Diagnostic: Provided by PATH workers during the times they are conducing outreach. This is done through mental status exams, mental health screenings, and crisis stabilization interventions.

- Habilitation and Rehabilitation: Provided by PATH workers through engagement and outreach to individuals not linked up with supportive housing, case management, counseling, treatment, or any other mental health services.
- Community Mental Health: pro vided by PATH workers and a number of divisions within mental health to put together a comprehensive spectrum of services ranging from intensive assessment of emergency services, to long term case management and on site supports of consumers where they live.
- Staff Training: All mental health staff at the Fairfax-Falls Church CSB is encouraged to attend trainings. The FFX CSB offers four trainings a year. In addition to those trainings, the PATH workers are encouraged to participate in the SAMHSA trainings and PATH trainings that are offered.
- Case Management: Provided by mental health therapists in a variety of different settings ranging from hospitals to drop in's at consumer's homes.
- Housing Services (i.e., matching persons with appropriate housing, technical assistance, and improving coordination) Performed by a mental health therapist in conjunction with the client.
- Supportive and Supervisory Services in Residential Settings: Performed by mental health therapists in residential settings.
- Referrals
- Housing Services, only including the following eligible services: planning of housing; improving the coordination of housing services; costs associated with matching eligible homeless individuals with appropriate housing situations.

c. <u>Community organizations that provide key services</u>

Housing placements and services are available to the target population via several community-based providers as well as via ARS. Such programs offer services through SNHIP, SSHP, SHOP, Shelter Plus Care, Dollar Lease, and Bridge program. Names of such programs include: Max's Place (Safe Haven), Homestretch, Rising Hope, and various transitional housing programs, offered through such agencies as: Pathways, Inc., Christian Relief Services, Northern Virginia Family Services, Department of Family Services, Lutheran Social Services, New Hope Housing, Volunteers of America, Reston Interfaith, and Shelter House.

ARS oversees approximately 250 sites, serving over 300 clients, all across Fairfax County. Housing options include the following programs:

*Special Needs Homeless Initiative (Section 8)* - Fairfax County Redevelopment and Housing Authority sets aside 25 Section 8 Certificates for disabled adults who are homeless and receiving services from the CSB. ARS and Pathways, Inc operate a significant number.

*Supported Shared Housing Program (Public Housing)* - Thirty-five persons with mental illness or substance abuse disabilities are eligible for set aside units. These adults who have experienced chronic housing displacement receive specialized applicant screening and supportive services through ARS.

*Supported Housing Options Program* - A state initiative administered jointly by the CSB and Pathways, Inc. Pathways, Inc. is a non-profit community based organization providing supported housing for seriously mentally ill persons, along with dually

diagnosed persons; Pathways is another major provider of housing and services to people who qualify for PATH enrollment. The SHOP program specifically targets persons who are homeless. Mental health consumers serve as peer counselors who work under the supervision of ARS residential staff.
*Shelter Plus Care* - A series of HUD Shelter Plus Care grants provided for the expansion of the SHOP model program targeting the homeless SMI or dually diagnosed population and some beds also target homeless SMI veterans. This is the category in which ARS established 12 more beds for DD homeless persons, also run jointly with Pathways, Inc.
*Bridge Program* - Transitional housing placement for homeless adults operated by United Community Ministries and supported by ARS Homeless Services staff.

*Dollar Lease* - Another joint project in which Christian Relief Services obtains HUD foreclosed properties and PATH/Outreach staff provides necessary aftercare support.

*Transitional Therapeutic Apartment Program* – An ARS operated program, TTAP provides supportive transitional and rehabilitative services in a 12 to 18 month program for SMI adults.

*Transitional Supervised Apartment Program* – See 3f below.

*Transitional Group Homes* – A one-year to 18-month program with 24-hour staff support for the residents. Emphasis is placed on teaching Independent Activities of Daily Living, and routinization of daily tasks to enhance mental stability and progress to more independent living.

*Franconia Road Treatment Center, Residential Extensive Dual Diagnosis Program and Cornerstones Homes*: These three programs provide dynamic co-occurring disorders treatment to male and female clients. The programs implement integrated evidenced based treatment that is tailored to the needs of each individual client.

Furthermore, the Fairfax-Falls Church has a comprehensive spectrum of services that are provided by Alcohol and Drug services. These services range from long term intensive residential to outpatient groups.

Each of the PATH workers and CSB homeless staff work collaboratively to provide case management and referral services to meet the biopsychosocial needs of each individual client. This coordination can take place in the form of setting up a referral, physically transporting someone to an appointment, or providing the consumer with the necessary information to contact the source themselves. The PATH workers have endeavored to establish working collaborative relationships with the following organizations so that homeless consumers can have their needs met without a gap in services.

- Virginia DRS for employment
- Health Dept. for medical
- Local dentists for reduced dental care.
- Local MD’s willing to accept Medicaid

- Four Different faith based organizations that provide food, clothing etc. to the different catch mount areas of the county.
- All divisions of Alcohol and Drug Services and Mental Health Services
- Local Multicultural Organizations that specialize in advocating for Latin and Asian American needs.

Lastly, in addition to the three CSB outreach position supported partially by PATH funds, there are a number of other services in the County targeted to the homeless SMI population. The CSB/Mental Health Homeless Services unit includes 8.5 FTE therapists who are not funded with the PATH grant. These therapists provide some outreach services, but primarily provide shelter-based and aftercare mental health services. CSB/Alcohol and Drug Counselors also assist with the planning and treatment of dually diagnosed clients. Shelters are more open to serving the SMI population in part because of the support provided by CSB therapists and alcohol and drug counselors deployed on site. The CSB/Community Mental Health Centers provide a comprehensive array of services accessible to homeless mentally ill persons. Specifically, Comprehensive Day Treatment, Emergency Services, Crisis Care, Comprehensive Support Services, and Adult Residential Services are provided.

d. Gaps in the current service system

Gaps that exist that are labeled as "High" per the 2004 CoC Point in Time Survey analysis are:

- For Individuals – Emergency Shelter; Permanent Supportive Housing; Job Training; Substance Abuse Treatment; Housing Placement; services for Chronic Substance Abusers, Seriously Mentally Ill; Dually Diagnosed, and those with Chronic Health Problems.
- Affordable housing with the necessary supports in place to sustain semi-independence.
- For Families with Children – Emergency Shelter; Job Training; Substance Abuse Treatment; Mental Health Care; and services for Victims of Domestic Violence, Language Minorities, and None of the Above categories.

e. services available for clients with co-occurring mental illnesses and substance use disorders

The CSB deploys mental health and substance abuse staff directly to the shelters. Monthly (at least) meetings with mental health supervisors, substance abuse supervisors, and community-based operators assure continuation of closely collaborative work among all of these providers.

The Fairfax-Falls Church CSB directly operates the Franconia Road Treatment Center, Residential Extensive Dual Diagnosis Program and Cornerstones Homes: These three programs provide dynamic co-occurring disorders treatment to male and female clients. The programs implement integrated evidenced based treatment that is tailored to the needs of each individual client.

Lastly, last spring ARS opened 12 slots of Shelter Plus Care beds, designated for those dually diagnosed with MH/ADS issues, and of course these are also designated for homeless persons per HUD's definition. This program is organized and run jointly by ARS and Pathways Homes, with CoC project monies.

The Fairfax-Falls Church CSB is examining Co-occurring disorders treatment as a whole. While this has been happening both Mental Health and Alcohol and Drug have began to expand the capacity of their programming to serve individuals with co-occurring disorders. This has been done through relaxing of admission criteria, implementing co-occurring disorder tracts within programs and expansion of medication clinic services. Overall the entire CSB has expanded its capacity to work with individuals with co-occurring disorders and integrated the concept that consumers having some type of co-occurring disorders are typically the rule and not the exception.

f. Strategies for making suitable housing available to PATH clients

One strategy to address this concern is that whenever beds that are designated for HUD-defined homeless person become available, the ARS Managers and Division Director first look at people on the waitlist for such programs; we incorporated a "highlighter symbol" long ago to clearly indicate homeless persons, so that they stand out even if on a waitlist that is not "Homeless Only." Also, much time and effort are spent in ARS Management meetings and follow-ups to get current names and recommendations from Homeless Services staff of homeless persons they know who are ready and willing to make use of such programming. Lastly, continued active partnering with private non-profit agencies allows the CSB to participate in HUD-funded programming by providing management, some staff, and leverage agreements with these private non-profits.

Housing placements that combine low barriers to easy access with provision of levels of mental health care with which residents would be willing to engage have become a recent strong focus of the Adult Residential Services (ARS) Unit (Homeless Services are offered through this unit). Two recent program adaptations have been implemented. Firstly, we have already transitioned homeless mentally ill persons into the Transitional Supervised Apartment Program (TSAP). This offshoot of the existing Transitional Therapeutic Apartment Program (TTAP) requires minimal treatment engagement from the residents, and focuses on providing residents with a safe, stable living environment while they do as much as they can to reintegrate into the community. All referrals are taken from Homeless Services outreach and shelter-based therapists who have identified homeless mentally ill persons who have been unsuccessful in making use of existing housing resources. This program is a close collaboration of outreach therapists, shelter-based therapists, apartment program staff, supervisors and managers. Another highlight of this programming is that it follows a model of thoroughly planned transition phases to assist the resident in gaining trust and rapport with the "new" apartment program therapist. The shelter-based or outreach therapist meets jointly with the resident and "new" therapist to help the resident become more comfortable with the apartment therapist, while also allowing the homeless services staff the opportunity to educate and

model successful interactions with the homeless mentally ill population. Therefore the extended transition phase could last for a couple weeks, or for a couple months if needed.

As a community, Fairfax County has recently redesigned its continuum of care committee to be more proactive in seeking housing and alternate sources of funding for appropriate affordable housing. In this re-design the Continuum of Care has been broken into two sub-categories, the Community Council on Homelessness and the Community Forum on Homelessness. In those sub-categories five different tasks categories were created. They are Advocacy/Education, Resource Development, Program Development, Monitoring/Evaluation, and Community planning. Each of the above committees has been tasked with establishing a strategic plan on improving services to the homeless in that area.

Furthermore, Adult Residential Services has taken on a project of streamlining the referral process for Homeless consumers to be considered for residential services. This streamlined process should allow homeless individuals to be placed somewhere in the residential treatment continuum that was described in 3c in a more expedient fashion.

**4. Coordination with HUD Continuum of Care**:
See 3c, this application.

Additionally, in order to maintain and enhance cooperation and success with CoC providers, 4 CSB supervisors/managers attend the numerous CoC meetings held with all community members. This entails monthly to twice-monthly meetings of 3-4 hours beginning in August and continuing through June. Also, we participate in technical reviews, leveraging, voting for projects, Point In Time participation, and various meetings as necessary with community providers wanting to plan directly with us on new programs.

As a community, Fairfax County has recently redesigned its continuum of care committee to be more proactive in seeking housing and alternate sources of funding for appropriate affordable housing. In this re-design the Continuum of Care has been broken into two sub-categories, the Community Council on Homelessness and the Community Forum on Homelessness. In those sub-categories five different tasks categories were created. They are Advocacy/Education, Resource Development, Program Development, Monitoring/Evaluation, and Community planning. Each of the above committees has been tasked with establishing a strategic plan on improving services to the homeless in that area. The goal of this overall Continuum of Care is to develop a web of comprehensive services and an ongoing proactive plan to reduce homelessness and better address homelessness when it occurs in Fairfax County.

The PATH workers provide direct feedback to this entire process of planning and proactive movement. All of the PATH workers supervisors serve as members of at least one of the above committee's to take and active role in the planning process.

**5. Cultural Competence**:

The CSB has 1102 full and part time employees.

| CSB Staff | Community Profile | Category |
|---|---|---|
| 64.3% | 73% | White |
| 25.0% | 9% | Black |
| 5.1% | 11%(of total) | Latino |
| 0.5% | 0% | American Indian/Alaskan |
| 5.1% | 13% | Asian Pacific/Islander |

There are presently 3 PATH workers:

3 100% Caucasian females

Over the past year the PATH workers received no training on Cultural Competence. The senior management in Mental Health and the PATH supervisors did attend diversity training. This same diversity training is slated to be provided to all therapists in the Mental Health System over the next year.

For the past several years, CSB Senior Management has actively run a Workplace Planning and Development workgroup, which meets once or twice monthly. Out of this group has come a subgroup of MH Diversity, which works on the cultural competence issues of staff, management, programs, and consumer needs. Topics have included and continue to include: up-to-date training of all MH staff via the County's Diversity Trainings which are offered ongoing; working up a strategy and actively pursuing diversity within graduate students to get placements. The MH Diversity committee has continued to work on having a balanced workforce that reflects the needs of the community in which they work. As a part of this they have reviewed SAMSHA's cultural competence standards, NASW's cultural competence standards, and The Office of Minority Health Public Health Service recommendations for National Standards and an Outcomes-focused research agenda. After reviewing these standards and recommendations the MH system decided that they needed to adopt their own standards for cultural competence. Presently, we are in the process of adopting those standards and securing funds to implement the recommendations that will be contained therein. One of the standards that have already been included in draft format is the mandatory provision of a yearly training to clinical staff in the mental health system on best cultural competence practices.

Our Homeless Services staff incorporates a balanced mixture of gender and ages, as well as staff from African-American, Vietnamese, Caucasian, Middle Eastern backgrounds. In addition to utilizing these staff's abilities to speak Vietnamese, Farsi, English, and Sign Language, the county provides and pays for on-call interpreters as needed. Outreach workers actively cultivate working relationships with diverse community groups, through churches, mosques, synagogues, community based providers, etc. The Continuum of Care has members belonging to Kurdish Human Rights Watch, Indian community groups, and a wide variety of races/ethnicities/genders/ages.

The County continues to strategize and pursue programming which provides the cultural, linguistic, and ethnic services to our diverse community. Just one example is the County's

Annual Report for 2002 distributed to citizens via printed copies and web site versions – pictures and examples include all genders, races, ages, socioeconomic groups, and so on. When walking into a county facility one sees signs interpreted into sometimes 5 or more languages.

**6. <u>Consumer/Family Involvement</u>**:

The Continuum of Care re-design is continually looking for client advocates and consumers to be a part of the planning process. Furthermore, the Fairfax-Falls Church CSB is presently pursuing a grant to expand capacity to serve substance abusing and severe and persistently mentally ill homeless individuals.

Furthermore, the Fairfax-Falls Church has taken on integrating the consumer focused recovery model approach into it's planning and services. To this end, all workgroups and policy committee's actively seek out and value consumer involvement and input. An example of this is a recent redesign of the Mental Health Day program continuum of services offered in Fairfax County. This redesign was a year long process that involved the CSB, multiple private agencies, and several consumers and family members.

Since PATH funding pays for 2 of our 3 Outreach positions, plus $4000 toward travel-related expenses, we must look at the groups listed in the question and their input at phases of PATH-type activities within the context of all 3 Outreach workers, Continuum of Care, and ARS planning and development. Vigorously pursuing homeless persons to participate in the Point in Time survey is one of the tools we use to get input from and coordinate directly with homeless persons and their families. The CoC priorities are generated from these gaps analyses. Also, active community involvement targeting needs of homeless persons continues to be an ongoing facet of the Max's Place (Safe Havens) program. The Homeless Services Manager attends the semi-monthly meetings, which include representation from the county supervisor of that district.

Last year I reported that ARS formed an ad hoc workgroup to explore various types of SRO/Single Person Efficiency housing and treatment. This past year, we visited a successful SRO model developed and run by Volunteers of America in Baltimore City. Currently, because of community discussion as to how to reutilize Lorton Prison grounds and buildings, the county Deputy Executive has directly been participating in SRO/Single Person Efficiency discussion. He and the County Executive have had focus groups, planning meetings, and workgroups with county staff, management as well as with numerous county citizens, consumers, and agencies. Even if this Laurel Hill initiative does not come through (for example, transportation in and around that area is a large hindrance at this point), we are hopeful that in the near future this typed of housing and programming will be endorsed by the community and established at some other county location. Again, this would be a low-demand, easy placement for homeless mentally ill persons, some of whom are expected to also have substance abuse issues. Levels of treatment would be tailored to the residents' willingness and ability to engage in treatment, and a resident manager would be on site.

**Budget Form** Fairfax-Falls Church CSB FFY04/SFY05

| Category | | | PATH Funded Amount | Non-Federal Direct Match | Source of Match Cash or In-Kind *( delete one*) |
|---|---|---|---|---|---|
| **Staff Title** | **Annual Salary** | **FTE** | | | |
| Outreach Staff | [redacted] | [redacted] | [redacted] | [redacted] | Cash |
| Outreach Staff | [redacted] | [redacted] | [redacted] | [redacted] | Cash |
| Outreach Staff | [redacted] | [redacted] | [redacted] | [redacted] | Cash |
| | | | | | Cash / In-Kind |
| | | | | | Cash / In-Kind |
| **TOTAL PERSONNEL** | | | [redacted] | [redacted] | Cash |
| **TOTAL FRINGE BENEFITS** | | | [redacted] | [redacted] | Cash |
| **Travel** *e.g.: Outreach, or travel to training, or travel to state meetings* | | | | | |
| Vehicle fuel, replacement fund, maintenance and repair expenses, mileage | | | [redacted] | [redacted] | Cash |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Equipment List** *individually any non-expendable, tangible personal property having a useful life of more than one year.* | | | | | |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Supplies** *e.g.: Program Supplies or Computer Software* | | | | | |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Contractual If** *more contracted services, attach an additional sheet with description.* | | | | | |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Other** *Describe any other proposed expenditures* | | | | | |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| | | | **PATH** | **Match** | |
| **Total PATH Budget** | | | $154,597.00 | $ 51,532 | |

Note: The PATH budget period runs from 9/1/04 through 8/31/05, even though the reporting period runs from 7/1/04 through 6/30/05.
You will be paid from the current PATH budget for July and August 2004.

**1.** **Provider Organization:**

NAME: **Hampton-Newport News Community Services Board**
TYPE: **Community Services Board**
REGION: **City of Hampton, City of Newport News**
SERVICES: Adult Case Management, Program for Assertive Community Treatment, Psychosocial Rehabilitation, MH Residential, MH Supported Living, Respite, Vocational, Partial Hospitalization, PATH, MR Day Support, MR Residential, MR Supported Living, Medications Management, Adult Day Care, Regional Deaf Services, Children's Case Management, Substance Abuse Prevention and Early Intervention, Psychological Assessments and Evaluations, Comprehensive Outpatient Services, Emergency and Crisis Services, In-home Treatment, Criminal Justice Services, HIV/AIDS Early Intervention and Outreach, SA Treatment, Children's Residential, Independent Living, Crisis Stabilization, Inpatient Services, Intensive Adolescent Outpatient SA Services, Service Coordination to pregnant and post-partum women and children, Opioid Replacement Services, SA Support Services, Juvenile Detention Services, Hampton Drug Treatment Court, Newport News Drug Court.

**2.** **PATH Funds**: The PATH base award for Hampton-Newport News Community Services Board for SFY 04-05 is $78,282 with an incentive award of $13,815 for a total award of $92,097. The required match is $30,699. This match is provided from net earned fee revenues from other programs and from State mental health general funds allocated to the Hampton-Newport News Community Services Board and will be available on July 1, 2004. Total budget for this project is $130,067 for Fiscal Year 2005

Staffing and Fringe Benefits: Two full time staff are engaged for this project, a case manager and a Peer Counselor. Total Salaries are $[redacted]. Benefit costs of $[redacted] include payroll taxes, health insurance, disability and life insurance, contribution to the Virginia Retirement System, and Worker's Compensation insurance. Detailed amounts and rate calculations for each of these line items are shown in the budget.

Travel Expense: Local mileage is paid at the rate of $0.32 per mile. Airfare, Lodging and Meals for conference attendance are budgeted at $[redacted]. Vehicle operation and insurance are budgeted for $[redacted].

Supplies: Office and educational/recreational supply expense is budgeted for $[redacted]

Contractual: Assigned space utilization cost of $[redacted] and costs for telephone and pager for assigned staff [redacted]) are budgeted.

Training has been budgeted at $[redacted].

Client support costs of $[redacted] include $[redacted] for client housing ([redacted]% of allocated Federal PATH funds), $ [redacted] for client transportation, $ [redacted] for client medications and $ [redacted] for other client support items.

3. **Services Plan:**

a. projected number of clients who will receive PATH funded services

The total number of clients enrolled in FY 2005 is targeted at 300. A total number of 400 contacts will be made over the course of the year and from these contacts the goal of 300 seriously mentally ill homeless PATH clients will be served. It is estimated that a total of 270 persons or 90% will be "literally homeless".

b. list and describe how specific services are to be provided

- The PATH worker will provide **outreach** to the mentally ill homeless population.
- These outreach services will include **screening and diagnostic services** used to best identify appropriate services and referrals.
- The PATH worker will provide **referrals and linkages to community mental health services and alcohol and drug treatment services, referrals to primary health providers (like PICH), psychosocial rehabilitation services, education, and vocational services**.
- All PATH enrollments will receive **case management services, linkages to appropriate housing options, technical assistance with housing applications, and coordination of housing with other service components**.
- Services that are coordinated with PATH supported services, but are not fully funded by PATH, are **emergency housing/shelter, additional housing and rental assistance, bus tickets for transportation to appointments, purchasing medication, food, clothing and dental services**. These services are provided in **residential settings and for those living on the streets or other non-residential settings**.
- Additional areas of assistance include **payments for past due or overdue housing and utility bills, security deposits and one-time payments on eviction notices to prevent homelessness.**

c. community organizations that provide key services

HNNCSB offers PATH clients a myriad of services on-site that are accessed by the PATH case manager. These services include: emergency services, case management, PACT team, outpatient mental health services, medication services, psychosocial rehabilitation day services, vocational services, partial hospitalization program, access to in-patient treatment and discharge planning, services for pregnant women with substance abuse histories and women with children with substance abuse disorders, HIV prevention and intervention services, extensive substance abuse services including: treatment readiness groups, day treatment, residential treatment services, methadone and lam clinics, SA case management services, and clinical staff which includes a psychiatrist specializing in providing services to, and coordinating services for clients with co-occurring mental illnesses and substance abuse disorders. HNNCSB also has staff available to the PATH clients to assist with preparation of applications for Social Security, Social Services, Medicaid and other benefits and to assist in the appeals process if clients are denied benefits. HNNCSB has also developed an extensive array of housing options available for the PATH clients, including: emergency housing, Shelter Plus Care housing, Safe Harbors – A Safe Haven, Mental Health Supported and Supervised housing, and in-home Supported Living Services. Children's Services (case management, etc.) are also available and have been a referral source for children of PATH clients, when appropriate.

PATH Eligible Clients are provided services through linkages offered by the PATH case manager. Temporary housing services are provided by the Hampton-Newport News Community Services Board, Friends of the Homeless Shelter, Peninsula Rescue Mission, Transitions Inc. (Formerly VA Peninsula Council on Domestic Violence), Menchville House, Veterans Homeless Housing programs, and HELP House (Hampton Ecumenical Lodgings and Provisions). These shelters operate year-round. The year-round shelters provide referrals to the PATH worker, if the need is recognized. They encourage outreach efforts made by the PATH case manager.

Newport News LINK (Living Interfaith Network) and HELP both coordinate winter shelters that target the non-sheltered homeless – PORT and A Night's Welcome. They are in operation from late October through early April. Both LINK and HELP also provide financial assistance for other non-PATH funded services.

Healthcare for the Homeless provides primary health care to PATH clients. Services included are medication assistance, transportation to appointments, and linkage to additional health services on an as needed basis. Referrals are made to PATH from Healthcare for the Homeless. Outreach efforts are encouraged at the various clinic sites. Dental services are provided through the local Health Departments and Old Dominion University School of Dentistry. Over the last year the PICH (Peninsula Institute for Community Health) has started a dental clinic. PICH offers full dental care on a sliding scale with a small one time registration fee.

d. gaps in the current service system

There has been no replacement of the 50-bed Salvation Army Family Shelter that closed over 2 years ago. Their 50-bed shelter was condemned due to serious building code problems. The program was terminated and although the Salvation Army is looking at options for reopening the shelter, no plans have been finalized and no replacement is likely for at least another year.

Both winter shelter programs experienced huge increases in demand for overnight shelter this past winter. The increase was so great that individuals risked not having shelter if they arrived too late, because the churches filled to over-capacity. Also, more rules were enacted and enforced that may have helped with operations, but resulted in more individuals on the "do not admit" lists or being temporarily not admitted. This past winter sheltering season indicated that if economic conditions continue, the Peninsula does have a serious gap in temporary shelter for homeless individuals (particularly for single men and women).

Also, the City of Newport News remains ineligible for Emergency Shelter Grant funds due to the 2000 Census. Although city officials are seeking review and reinstatement of these funds, this has resulted in a loss of $75,000 to homeless providers and another $300,000 loss in Continuum of Care funding. Both events will likely reduce or eliminate some homeless services on the Peninsula and impact both the demand for PATH services and referral options available to PATH enrollees, creating gaps where none or only small gaps existed in the past.

Changes at the Veterans Administration resulted in national competition for the VA Per Diem Housing grants this year. As a result of this change, no service provider in this part of Virginia was awarded a Per Diem Housing grant for homeless veterans. The HNNCSB had been contracting with the VA for several years to provide such housing. This has resulted in a gap of transitional housing for homeless veterans on the Peninsula.

The catchment area continues without a social detox unit since the closing of Serenity House's detox unit, reducing the substance abuse treatment options for PATH participants on the Peninsula and creating a gap where none had existed in the past, waiting list length excluded.

Other gaps in local services are continuing to grow. Shelter space for the targeted population is often restricted by the local year-round shelters gate keeping procedures. Recent hospitalizations, jail, and detox stays within the last thirty days exclude potential PATH-eligible clients from securing shelter space. A second and large gap is locating affordable permanent housing. Hampton Redevelopment and Housing Authority (HRHA) reports an average of 12 months wait for public housing. HRHA's Section 8 program has been closed to new applicants for 12 months and is expected to stay closed for the next 12-24 months. Newport News Redevelopment and Housing Authority (NNRHA) are currently reporting a 6-12 month waiting list for public housing. NNRHA's Section 8 waiting list closed in January of 2000 and is expected to stay closed for an undetermined amount of time. NNRHA does provide the leasing service for the Warwick SRO (Single Room Occupancy) and this is a desirable location for PATH clients without families or dependents. The waiting list for the SRO is 6-9 months. Although there are some private sector housing and apartment options that are income-based, securing housing usually takes over 3 months to achieve. Often the private sector low-income options are less desirable due to additional utility payments and deposits. Shelter stays do not meet the time requirements for public housing waiting lists. Rooming and boarding houses are also frequently used by PATH clients as an alternative to shelter while waiting for public housing or other low income housing. Rent ranges from $50.00 to $100.00 a week which is usually not affordable for PATH clients. Recent zoning changes in both the City of Hampton and City of Newport News restricts the number of unrelated adults in boarding and rooming houses to 4 and 3 respectively without extensive planning authorization, thereby reducing the income needed by property owners to recoup the cost of providing this type of housing. This is resulting in fewer boarding home providers and more boarding home providers closing their doors.

e. <u>services available for clients with co-occurring mental illnesses and substance use disorders</u>

Services for clients with co-occurring substance abuse problems include an SA engagement group at the PORT winter shelter through a contract with LINK and referrals for SA evaluations and admissions to SA services. HNNCSB added a Substance Abuse Case Management Team in 2001 and a staff psychiatrist. Individuals hired in these services have considerable experience working with people with co-occurring disorders. The HNNCSB also operates a treatment readiness group called First Step. Following this is an intensive substance abuse day treatment program called Next Step. Both First Step and Next Step treatment programs are available to the target population. HNNCSB also operates a licensed Opioid Replacement Clinic. HNNCSB

contracts with Serenity House to provide residential substance abuse treatment. The wait for residential services can exceed 3 months.

Emergency housing is available for those individuals with co-occurring mental illnesses and substance abuse disorders. This is short term housing that could defer a hospitalization or provide a safe place until treatment is available. Persons with co-occurring disorders are also eligible for and residents of the HNNCSB Shelter Plus Care program and the Safe Haven.

HNNCSB hired a part-time psychiatrist last year who provides outpatient services to individuals with substance abuse as their primary diagnosis, but with co-occurring mental health diagnoses.

One local hospital and the Warwick SRO housing program offer 12-step meetings geared to the mentally ill substance abuser. Drug testing is available to the PATH case manager if the need arises to test PATH clients. Information on area 12-step meetings is available to all dual diagnosed clients. In addition, The Hampton-Newport News Community Services Board offers AA and NA meetings at two different locations. Detox services can be accessed with an out-of catchment referral to Virginia Beach Va. Medical Detox is available at the local psychiatric hospitals.

Through efforts initiated by the HNNCSB Director of Community Support Services and with the Medical Director as a participant, inter-disciplinary staffings between the medical staff and treatment staff are regularly held to coordinate the services of individuals with co-occurring disorders.

Also, the PATH Supervisor and staff, along with the Director of Community Support Services, is participating in a local coalition of agencies to develop a new program to serve the chronically homeless individuals with mental illnesses and substance abuse disorders. The plan, still in development, incorporates housing, day center, and coordinated services for this target population.

f. strategies for making suitable housing available to PATH clients

Over the past several years, the Hampton Newport News Community Services Board has expanded the development of a variety of housing options in order to meet the expressed housing needs of consumers, to help provide consumers with safe, decent housing provided by a landlord who has an understanding of their needs and is willing to work with residents clinically in order to avoid evictions or unstable housing conditions, and to increase access to the amount of affordable housing available to the PATH consumers. Housing options available through HNNCSB are open to persons with co-occurring serious mental illnesses and substance abuse disorders.

HNNCSB offers PATH clients housing options that include: payments to prevent evictions of PATH clients (at-risk of homelessness) and financial assistance to access housing. PATH funds help PATH clients obtain housing.

In 1997, HNNCSB developed an emergency housing program offering shelter and services to individuals with mental illnesses and substance abuse disorders who were inappropriate for other shelter programs or who have exhausted other program time requirements. This program has expanded to 8-beds, 4 beds for women and 4 beds for men. Housing, food and support services are offered. Some PATH funds help off-set the cost of the emergency housing.

In 1999, the HNNCSB developed a Shelter Plus Care permanent housing program in partnership with the Newport News Redevelopment and Housing Authority. This program provides permanent supported housing to homeless, seriously mentally ill clients through a grant provided by HUD's Continuum of Care Supportive Housing Program. Seven apartments have been designated to the Shelter Plus Care program and can assist up to fourteen individuals at a time with permanent housing. These seven apartments are located in the Adams Woods Apartment Complex which is owned and operated by the Hampton-Newport News Community Services Board. The Emergency Housing Program is also located on the same site.

The Hampton-Newport News Community Services Board has two additional apartment complexes that it owns and operates: Queens Court and Bay Port Apartments. Queen's Court offers a supervised, congregate unit as well as ten units with mental health supported living services. The Hampton Newport News Community Services Board Residential Services has also expanded into privately owned apartment complexes. All PATH clients are eligible to apply for these permanent housing programs. Referrals to residential services can be generated by the PATH case manager. PATH funds assist PATH clients in accessing HNNCSB housing options, if necessary.

The PATH case manager is well trained in assisting PATH clients in the application of both public and private market housing by helping to obtain needed documentation and identification for the application and assisting with denials and turn-downs by advocating on behalf of PATH clients and filing appeals. Additionally, the PATH case manager attempts to stretch the shelter stay and emergency housing stay to meet the waiting period of most housing lists. The PATH case manager always advocates for the mentally ill homeless population with different housing providers. The PATH case manager also links to additional supportive services to help reduce the risk of the client not maintain their housing.

HNNCSB was awarded a HUD Supportive Housing grant to provide a Safe Haven. This 8 bed program operates in leased units in the city of Hampton and provides housing and service-engagement strategies. The PATH case manager is the referral source for participants and continues to provide case management services until the individuals indicate a readiness for mainstream mental health services.

HNNCSB also provides a housing oversight program of area boarding homes on behalf of clients. In this capacity the HNNCSB helps to ensure that safe and decent housing is provided within these unlicensed settings, assists in the resolution of conflicts between the resident and landlord and helps to assist with transition from boarding houses to other housing options. In addition, PATH funds assist PATH clients with some housing rental assistance to obtain housing in these boarding homes.

4. **Coordination with HUD Continuum of Care:**

HNN has a long and dedicated role within the Greater Virginia Peninsula Continuum of Care Council (GVPCCC). HNNCSB Community Support Services Division (CSS) staff and PATH staff are extensively involved in the local Continuum of Care Council and activities. Currently PATH funded services are coordinated with the local Continuum of Care plans. Of significance to the local Continuum of Care are the housing programs developed by the HNNCSB, CSS Division, and which have considerable PATH staff supervision and oversight. These housing programs - Shelter Plus Care, the Safe Haven and the emergency housing are targeted primarily to the chronically homeless population who have mental illnesses and substance abuse. Since HUD has chronic homelessness as a major focus, the CSS housing programs are the cornerstone of the region's efforts to "end chronic homelessness in 10 years". The PATH case manager, Sherry Owens, attends the monthly Continuum of Care Council meetings and sits on the Homeless Committee. This committee is geared to helping all agencies providing services to the homeless increase communication and to improve continuity of care for the homeless population. The supervisor, Dee Schwartz also sits on the Continuum of Care Task Force. This committee is designed to identify services and housing barriers for the homeless population, develop local planning strategies to end homelessness and to oversee the development of the Continuum of Care statement. This is also a multi-agency committee with the goal of improving access to low and moderate housing to the at-risk homeless and homeless populations. The PATH program assists with the annual point in time analysis. PATH has been an essential part of the point in time analysis in the area of counting the non-sheltered homeless.

In addition, a HNNCSB staff person (working closely with PATH staff) sits on the state Virginia Interagency Action Council for the Homeless (VIACH) and is participating in the development of the state 10-year plan to end chronic homelessness as part of the Bush Administration initiatives. This staff member was a state delegate to the Virginia Team for the federally sponsored Policy Academy on Chronic Homelessness – representing the Virginia Interagency Council for the Homeless, the GVP Continuum of Care Council, and the HNNCSB.

Local Consolidated Plan updates include at least one public forum offered by the Continuum of Care Council. As members of the Council, the PATH Case Manager and Supervisor have opportunities to provide input during these forums. HNNCSB, Community Support Services Division staff is given draft copies to review and edit with regard to homelessness and mental health service provisions. These edited copies are included in the public submission of these documents. The CSB receives copies of the Consolidated Plans to use to coordinate housing and other services. Consolidated Plans are reviewed in the development of new housing, other resources, and relevant grant applications for consumers of HNNCSB services.

Also, the PATH Supervisor, with the Director of Community Support Services, is participating in a local coalition of agencies to develop a new program to serve the chronically homeless individuals with mental illnesses and substance abuse disorders. The plan, still in development, incorporates housing, day center, and coordinated services for this target population.

5. **Cultural Competence**:

| | Agency | PATH | Community |
|---|---|---|---|
| Asian | 0.82% | | 2% |
| Black/African-American | 63.7% | | 43% |
| Hispanic/Latino | 0.68% | 33.3% | 4% (of total) |
| White | 32.8% | 66.6% | 53% |
| Other | 2.0% | | 4% |
| Total agency profile | 100% | | |

HNNCSB has been providing services to the target population for over ten years – first through PATH, then through participation as one of only 18 ACCESS Demonstration Project sites in the nation, then through extensive housing programs. As evidenced by the many positive outcomes, such as the high percentage of placement of homeless individuals in permanent housing, staff and agency administration demonstrate the high degree of knowledge of the needs of the target population as well as the resources throughout the community.

To increase cultural competence, the Hampton Newport News Community Services Board offers staff training to address the issues of diversity. It is mandatory for all employees to attend Cultural Diversity Training in addition to Human Rights and Confidentiality Training. A broad range of community resources aids the FTE PATH case manager and peer counselor with linkages to services that address the areas of race, religion and culture. The FTE PATH case manager and peer counselor have the knowledge and experience of supervisors and other staff as an available resource for consultation if needed. In addition, one staff member working with PATH attends annual Fair Housing and Virginia Landlord Tenant Act workshops to keep current on issues that continue to impact PATH consumers due to race, culture, disability, ethnicity, etc. PATH staff and Supervisor attend the annual Health Care for the Homeless Conference where additional training is obtained includeing cultural competency information.

The HNNCSB has a good track record for expanded employment opportunities for consumers as part of program support staff. As peer counselors or peer support staff, these individuals represent the target population in the gender/age/cultural diversity of staff and assist other staff in understanding the needs of the target population.

An example of how HNNCSB approaches cultural competency is illustrated by the Deaf Services program. The HNNCSB is a regional service center for the deaf and hard of hearing; it has developed an extensive deaf services program, provided training for staff on American Sign Language, and provided training on deaf culture. These training opportunities include all CSB staff, not just those directly responsible for providing services to these consumers. This is an example of how HNNCSB is constantly striving to provide appropriate services in an environment that is culturally sensitive and knowledgeable about the individuals it serves. As consumers are identified who need specific assistance and who speak languages other than English, HNNCSB staff assist in obtaining the services of bilingual and bicultural resources. In the recent past, this has included individuals who spoke Chinese, Vietnamese, Bosnian, Croatian, and Spanish, many of whom are HNNCSB staff.

6. **Consumer/Family Involvement**

HNNCSB believes strongly in the policy of including homeless and formerly homeless persons in the operations and policy development of our services, to the extent that their opinions affect decisions at all levels of the organization. HNNCSB does not include homeless and formerly homeless persons because it is required – it does so because it is good business.

PATH clients, living in the HNNCSB Emergency Housing, are responsible for the daily operation of the shelter. These homeless individuals plan the shopping, cooking, and menu planning. They determine chore lists and community living rules with PATH staff helping to ensure that the rules are followed. House meetings are held to allow residents to work out conflicts and handle interpersonal issues; staff is available to mediate the proceedings.

PATH clients always participate in the development of their own Individual Service Plan which identifies various goals and outcomes the resident hopes to obtain, including mental health/substance abuse services, housing, obtaining appropriate benefits, and vocational/ employment goals. Family members are encouraged to participate in treatment planning when consent is given by the client and confidentiality of all parties adheres to policy.

At intake consumers and family members are informed verbally and in writing of their rights concerning services and treatment, information disclosure, treatment options, their right to choose the most appropriate services in their opinion, confidentiality policies and contact names, addresses and phone numbers for complaints, appeals, and consumer advocates.

As part of regular HNNCSB program evaluations, PATH clients are given Consumers Satisfaction Surveys. The PATH Supervisor ensures that these surveys are distributed and collected, the results analyzed and suggestions incorporated into program improvements.

Two formerly homeless individuals and formerly PATH clients have been members of the regional Local Human Rights Commission.

Consumers and/or family members are currently sitting directors on the HNNCSB Board of Directors.

A formerly homeless individual is a member of the HNNCSB Consumer Advocacy Council and has been an active participant in communicating the needs of homeless individuals with regard to program development.

Homeless and formerly homeless individuals and PATH clients participate in Lassen House Day Services and participate in daily Community Meetings addressing operational and policy issues. The meetings are chaired by consumers, including one formerly homeless chairperson.

The HNNCSB has hired several formerly homeless individuals either through its consumer-hire positions or regular staff positions. In this capacity, these program support staff provides valuable information with regard to the development, management, operations, supervision and evaluation of programs appropriate to meeting the needs of homeless individuals.

HNNCSB has taken the lead in the development of a Collaborative Homeless Initiative to serve individuals with mental illness who are chronically homeless. The PATH Supervisor and case manager are members of the interagency planning team working on the development of the proposal to provide housing and services targeting this very difficult homeless population. It is planned that PATH clients will participate in this new program development.

HNNCSB is the host site for the local chapter of the National Alliance for the Mentally Ill (NAMI) and provides staff support for this important advocacy group. NAMI Hampton-Newport News meets on the first Monday of every month at the Community Services Board. Information on NAMI is available to family members and participation is encouraged.

**Budget Form** Hampton Newport News CSB FFY04 / SFY05

| Category | | | PATH Funded Amount | Non-Federal Direct Match | Source of Match Cash or In-Kind *( delete one)* |
|---|---|---|---|---|---|
| **Staff Title** | **Annual Salary** | **FTE** | | | |
| Case Manager | [redacted] | [redacted] | [redacted] | [redacted] | Cash |
| Peer Counselor | [redacted] | [redacted] | [redacted] | [redacted] | Cash |
| | | | | | Cash / In-Kind |
| | | | | | Cash / In-Kind |
| | | | | | Cash / In-Kind |
| | | | | | Cash / In-Kind |
| **TOTAL PERSONNEL** | | | [redacted] | [redacted] | Cash / |
| **TOTAL FRINGE BENEFITS** | | | [redacted] | [redacted] | Cash / |
| **Travel** *e.g.: Outreach, or travel to training, or travel to state meetings* | | | | | |
| Local Mileage | | | [redacted] | [redacted] | In-Kind |
| Conf | | | [redacted] | [redacted] | Cash |
| Vehicle Operation and Insurance | | | [redacted] | [redacted] | In-Kind |
| **Equipment** *List individually any non-expendable, tangible personal property having a useful life of more than one year.* | | | | | |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Supplies** *e.g.: Program Supplies or Computer Software* | | | | | |
| Office and Educational Supplies | | | [redacted] | [redacted] | In-Kind |
| | | | **$** | **$** | Cash / In-Kind |
| | | | **$** | **$** | Cash / In-Kind |
| **Contractual** *If more contracted services, attach an additional sheet with description.* | | | | | |
| Telephone/Pagers | | | [redacted] | [redacted] | In-Kind |
| Rent | | | [redacted] | [redacted] | In-Kind |
| **Other** *Describe any other proposed expenditures* | | | | | |
| **Training** | | | [redacted] | [redacted] | Cash |
| **Client support** | | | [redacted] | [redacted] | Cash & In-kind |
| | | | **PATH** | **Match** | |
| **Total PATH Budget** | | | **$ 92,097** | **$ 37,970** | |

Note: The PATH budget period runs from 9/1/04 through 8/31/05, even though the reporting period runs from 7/1/04 through 6/30/05.
You will be paid from the current PATH budget for July and August 2004.

**Provider Organization:**

**Loudoun Community Services Board** Serving Loudoun County (LCCSB) is the provider organization. The LCCSB provides case management and support services to persons with mental illnesses, including those who are homeless through various treatment programs and treatment teams. The treatment programs available are Emergency Services, Outpatient Therapy, Community Support Services, Supportive Living Services, Substance Abuse Services, and Psychosocial Rehabilitation.

**PATH Funds:**

The total PATH budget is $52,170.00 The LCCSB will receive $33,586.00 for 2K5 Federal PATH award. Local funding dollars will be available July 1, 2005 providing the match to the PATH funds and the balance of the budgeted amount. [redacted] percent of the funded amount will support one FTE outreach counselor. The [redacted] percent of the PATH funding will support the following: outreach and travel meetings, conferences, and workshops, equipment, office space, PATH inventory storage, tangible items, information packets and contractual services for emergency support.

**Services Plan**:

**The projected number of clients who will receive PATH funded services:**

Loudoun anticipates 84 consumers to be enrolled in FY 2005. 70% are expected to be literally homeless. Loudoun County PATH Program funds the existing Outreach Counselor position (37.5 hours/week) to provide case coordination services to homeless persons with serious mental illnesses in Loudoun County.

Entry, Emergency Services, Discharge Planning, Department of Social Services, and Loudoun County Housing Services network and sharing resources that directly improve the lives of homeless consumers. The coordination of services between the PATH counselor includes but not limited to participation in community coalition meetings, social services departmental meetings, community outreach with county law enforcement, United Way supported non-profit agencies. Referral are received from and made to Virginia regional and national PATH counselors.

The staff associated with the LCCSB's PATH funded services will be supervised by the Residential Program Development Manager. The PATH staff will receive referrals from other Loudoun County programs that identify homeless persons with serious mental illness. The PATH program will coordinate with Loudoun County homeless shelters to provide assistance to identified persons with serious mental illness.

**The following services to be provided to homeless consumers with PATH funds included:**

- Street outreach and assessments to homeless consumers,
- Outreach to county consumers in emergency shelters programs,
- Case Coordination of enrolled homeless consumers.

Homeless consumers will be referred to community support services:

1. Psychiatric evaluation and on-going psychopharmacological services
2. Psychosocial rehabilitation,
3. Outpatient therapy,
4. Supportive substance abuse treatment,
5. Supportive or supervisory services in residential settings,
6. Primary health services,
7. Employment training,
8. Adult educational services,
9. HIV education and prevention,
10. Veteran Housing Programs,
11. Alternate housing programs,
12. PATH Network of counselors for relocation supports,
13. Community Corrections,
14. Regional Probation and Parole,
15. Non-profit consumer support services.

**Community Organizations providing services to PATH eligible clients**

Loudoun Housing Opportunities Made Equal (Loudoun HOME) Coalition assists with additional support and coordination for homeless population in Loudoun County. These agencies include:

| | |
|---|---|
| American Red Cross | Area Agency on Aging |
| Bank of America | Birthright |
| Catoctin Free Clinic | Evans Ridge Apartments |
| ECHO | Graydon Manor |
| Friends of Loudoun Mental Health | Jeremiah House |
| Good Shepherd Alliance | KSI, Inc. |
| Healthy Families Loudoun | LAWS |
| Loudoun ARC | LINK |
| Leesburg Police Department | Loudoun Habitat for Humanity |
| Loudoun County Public Schools | Middleburg – FISH |
| Loudoun Interfaith Relief, Inc. | Salvation Army |
| Northern Virginia Family Service | Victim Witness Program |
| United Way of Loudoun County | Virginia Cooperative Extension |
| Windy Hill Foundation | Wingler House Apartment |
| United Way | Volunteers of America |

**Major existing programs providing services to PATH eligible clients and gaps in current service plan:**

The Loudoun County Community Services Board (LCCSB) provides case management and support services to persons with mental illnesses, including those who are homeless through various treatment programs and treatment teams. Case management services are provided through Outpatient Therapy, Community Support Services, Supportive Living

Services, Substance Abuse Services, and Friendship House once a consumer is admitted into mental health treatment and coordination of services are provided by the outreach counselor. Some of the LCCSB services are not PATH-funded. Loudoun County Housing Services offers alternative housing programs, Operation Match, Affordable Dwelling Unit Program and Housing Opportunity Program for PATH eligible clients. Loudoun Housing Opportunities Made Equal (Loudoun HOME) Coalition assists with additional support and coordination for homeless population in Loudoun County.

**Current and anticipated gaps in mental health and other needed services**

**Medication costs/ insurance:** Ensure utilization of all benefits for which individuals qualify for who are entitled to Medicaid, Medicare, State Pharmacy medications, Department of Rehabilitative Services, Salvation Army, INMED/MotherNet/Healthy Families Loudoun, Friends of Loudoun Mental Health, Virginia Hospitalization Program**,** and Drug Company sponsorship programs. Consumers without medical coverage and limited financial resources are eligible to receive basic medical care from Catoctin Free Clinic on a referral basis.

**Dental care:** Ensure utilization of all services for which individuals qualify for, including the Virginia Dental Association Donated Dental services Program and the Loudoun Health Department Dental Clinic Program.

**Transportation:** Facilitate utilization of Loudoun Transit Services, via Fixed Route and On-Demand, Salvation Army services, and private Medicaid Taxi service providers.

**Housing:** Ensure utilization of all services for which individuals qualify for Loudoun Housing Services and federally funded programs including Housing Choice Voucher, Operation Match and Affordable Dwelling Unit programs.

**Strategies for providing services to clients with co-occurring mental illnesses and substance use disorders:**

Plans for meeting the special needs of homeless clients with co-occurring serious mental illness and substance use disorders include referral to substance abuse evaluation, detoxification, rehabilitation and ongoing support and treatment. Outreach worker engages the consumer to assess mental status and effects of substance abuse. The contact can determine if client is a danger to himself or others. This contact may lead to the consumer being detained for safety. Efforts are made by the PATH worker as well as by LCCSB clinical staff to connect dually diagnosed consumers to AA/NA meetings and sponsors with some familiarity with their special needs. Schedules of substance abuse meetings in the local community are provided to the dually diagnosed consumers. Substance Abuse Services provide treatment and educational groups several times during the week to dually diagnosed clients engaged with mental health services.

**Strategies for making suitable housing available to PATH clients:**

Plans for making suitable housing available to PATH eligible individuals involve obtaining HUD Housing Choice Voucher through Loudoun County's Housing Services Department. Operation Match services, a group coordinated from Loudoun County Housing Services, provides screening, referral, and counseling assistance to low income and special needs clients in finding short- to long – term housing within and without Loudoun County. Another promising source of housing assistance would come from the Friends of Mental Health, which is a private non-profit advocacy group who raise funds to provide housing assistance to seriously mentally ill engaged individuals. The immediate availability of either of these sources for housing is obviously driven by demand and adequate funding.

Housing services include:

- technical assistance in applying into a housing program
- coordination of housing services
- credit education and repair assistance
- security deposits
- matching eligible homeless individuals with appropriate housing situations
- one-time rental payments to prevent eviction

**HUD Consolidated Plan and Continuum of Care Plan Coordination**

PATH-funded services will be coordinated with Loudoun County's HUD Consolidated Housing Plan and Continuum of Care Plan. The Outreach Counselor will ensure that clients receiving PATH-supported services are retained on the Loudoun County Housing Services HUD Housing Choice Voucher program waiting list for housing vouchers/certificates. The Supported Living Services staff and PATH counselor already represent the LCCSB at the bi-monthly Loudoun HOME meetings. The mission of Loudoun HOME is "to provide a strategy designed to foster Loudoun County citizens to become self sufficient by facilitating the diverse private and public community services to ensure effective utilization and networking of all resources."

This coalition serves to network and provide a consolidated support for any housing related initiatives in the Loudoun community. LCCSB's PATH services are important elements in the County's Continuum of Care Plan, and is supported in Loudoun's Consolidated Housing Action Plan**.** The gaps in services are quickly identified in the regular contacts with community agencies both public and private in Loudoun County. Each contact educates the community on the needs of homeless consumers in our area expanding the awareness of this population.

Emergency hotel placement may be provided to homeless consumers to help bridge the gap until a shelter bed becomes available or housing is secured. Financial assistance from area non-profit agencies including Friends of Loudoun Mental Health, Loudoun Interfaith, Inc., Link, Inc., Loudoun County Housing Services, and a few local religious

supporters subsidize housing placements. Loudoun County funded apartments also helps enrolled PATH consumers who receive case management from mental health services.

**Cultural Competence**:

The LCCSB Department of Mental Health & Substance Abuse Services includes 268 staff members. The race/ethnicity backgrounds contain 1(<1%) Native American, 8(3%) Hispanic, 9(3%) Asian/Pacific Islanders, 38(14%) Black non-Hispanic, 202(75%) white non-Hispanic, and 10(4%) non-classified. The PATH outreach worker is white. The community profile is 6% (of total) Hispanic, 5% Asian/Pacific Islander, 7% Black, 85% White, and 4% other.

The PATH Outreach Counselor will demonstrate sensitivity to age, gender, and racial/ethnic diversity. The background of the PATH outreach counselor is multicultural. His life experiences in the military and twelve years of mental health counseling contributes to his understanding and appreciation of the myriad of cultural differences among the PATH consumers. The counselor also receives ongoing in-service training through County Human Resources-sponsored training, SAHMSA audio conferences, Continuing Medication Education Inc, conferences on providing services to difficult and resistant clients. PATH coordinator is continuing her education credits for master's level certification. The PATH outreach worker arranges bi-monthly regional meetings with the designated PATH workers to develop effective strategies for this heterogeneous population within the region.

Consumers are provided with brochures describing PATH supported services, contact telephone numbers to the PATH Outreach worker, Emergency Services of Mental Health and Social Services Departments. These brochures are available in English and Spanish. Translators are available via Mental Health Services to other non-English speaking homeless consumers.

**Consumer/Family Involvement**:

Family members and consumers are represented on the LCCSB. Consumer and family involvement in the planning, implementation and evaluation of Loudoun's PATH program are fundamental to its success. Family members are solicited to assist with transition from last housing situation, (when involved) to include moving to new shelter placement, contact other family members for temporary housing solutions, or providing background information on the consumer.

In addition to the LCCSB's input, the Loudoun PATH program will seek feedback and support from various other advocacy organizations in Loudoun County (e.g., Supported Living Consumers Association, Loudoun Alliance for the Mentally Ill, Friends of Mental Health). These organizations are composed of consumers, family members and community leaders who are seriously committed to increasing the services to persons with serious mental illness. These organizations will be asked to complete an annual program evaluation of the PATH services Loudoun provides.

All consumers and associated family members will be fully informed of all rights to included:

- Health Information Portability & Accountability Privacy (HIPPA) Notice,
- Loudoun County CSB Policy of Human Rights,
- Release of Information,
- Access to emergency services,
- Participation in treatment decisions,
- Respect and non-discrimination,
- Complaints and appeals process,
- Consumer responsibilities.

Outcome data will be collected weekly by the Outreach Counselor, and compiled and reported with administrative staff support. In addition to the required PATH program quarterly reporting, Loudoun's PATH program will look to reduce homeless recidivism. It is hoped that by intervening in the community and providing solid mental health assessment and intensive case coordination to engaged consumers the program can get participants into appropriate mental health treatment and stable housing. Annual program evaluations will be conducted on Loudoun's PATH program. We will be seeking an internal review and external feedback from community-based advocacy groups and program participants.

The PATH program follows straightforward course of documentation to track services. Outreach contacts are tracked via a contact sheet that includes contact dates, identifying demographics, location(s), needed services and referral information. These documents record data identified from PATH quarterly and annual reporting forms. Data compilation for reporting is eased greatly with the use of these forms. Each contact provides immediate needs and opportunity for assessment of stability. Once enrollment status has been established, goals are noted and suitable strategies are planned for each individual situation to include referral to mental health professional, social services counselor, and county housing services. Follow-up with the consumer and primary case manager is continued to help with transition. If the consumer finds stable housing, maintains residences, and continues receiving support from support system, then the PATH consumer is closed. Data collection forms, HIPAA Notice, and program involvement forms are located at the end of the proposal.

**Budget Form** Loudoun County FFY04 / SFY 05

| **Category** | | | **PATH Funded Amount** | **Non-Federal Direct Match** | **Source of Match Cash or In-Kind** |
|---|---|---|---|---|---|
| **Staff Title** | **Annual Salary** | **FTE** | | | |
| *Senior Clinician* | [redacted] | [redacted] | [redacted] | | *Cash/In-Kind* |
| **TOTAL PERSONNEL** | | | [redacted] | | Cash / In-Kind |
| **TOTAL FRINGE BENEFITS** | | | | [redacted] | In-Kind |
| **Travel** *e.g.: Outreach or Travel to State Meetings* | | | | | |
| State Meeting and SAHMSA Conferences | | | [redacted] | [redacted] | In-Kind |
| Outreach Workshops and Training Conferences | | | [redacted] | [redacted] | In-Kind |
| **Equipment*** *List individually any non-expendable, tangible personal property having a useful life of more than one year.* | | | | | |
| Office Space and Workstation | | | [redacted] | [redacted] | In-Kind |
| Bicycle | | | [redacted] | | In-Kind |
| Containers, storage cabinets, shelves | | | [redacted] | | Cash |
| **Supplies** *e.g.: Program Supplies or Computer Software* | | | | | |
| Backpacks, sleeping bags, and toiletries | | | [redacted] | | Cash |
| Floppy and R/W CD, Folders, Film | | | | [redacted] | In-Kind |
| Printing Fee & Information Packets | | | [redacted] | | Cash |
| **Other** *Describe any other proposed expenditures* | | | | | |
| **Transportation** | | | [redacted] | [redacted] | In-Kind |
| Emergency Supports (Medical, Hotel, Food, Clothing, Deposits, Phone & Gas Cards, recreation center for showering) | | | [redacted] | | Cash |
| **Total PATH Budget** | | | **PATH** | **Match** | |
| | | | $33,586.00 | $ 18,584.00 | $52,170.00 |

Note: The PATH budget period runs from 9/1/04 through 8/31/05, even though the reporting period runs from 7/1/04 through 6/30/05.
You will be paid from the current PATH budget for July and August 2004. **Matching local funding** will be available at the beginning of the FY 2005-grant period.

| | |
|---|---|
| **Total Federal PATH dollars** | **$33,586.00** |
| **÷ Total PATH Budget** | **$52,170.00** |
| **= Proportion of Federal dollars** | **64%** |

**FY2005 PATH Application: Local Provider Intended Use Plan**
**Norfolk Community Services Board – PATH/Homeless Project**
**Norfolk, Virginia**

**1. <u>Provider Organization</u>:**

Organization Name: Norfolk Community Services Board
Organization Type: Community Services Board
Description of Services: The Norfolk CSB provides Mental Health, Substance Abuse and Mental Retardation Services. Under this umbrella of services, the CSB provides the following: Intake, Emergency Services, Case Management, Detoxification, Hospital and Facility Services, Housing and Residential Activities, Opioid Treatment, Psychiatric and Medication Management, Outreach, Counseling, Day Activities, Prevention Services, Youth Activities, and Infant Development.
Region Served: Norfolk, Virginia

**2. <u>PATH Funds:</u>**

Amount of PATH funds: $64,988 base allocation
$11, 468 performance allocation
$76,456 Total Award
$25,230 Local Match

Budget Narrative:

This budget includes the funding for 1.6 direct service FTE's and fringe benefits from the federal funds ($[redacted]) and a .2 FTE for supervisory responsibilities from in-kind match ($[redacted]).

$[redacted] in federal funds will be used for the Case Manager III to attend trainings and/or conferences. $[redacted] has been budgeted from federal funds and $[redacted] in cash to purchase supplies for clients including clothing, basic toiletries, food, medical supplies, etc. $[redacted] has been budgeted for space, insurances, office supplies, vehicle usage and other miscellaneous expense including $[redacted] in federal funds and $[redacted] in-kind match.

NCSB Match money will be available on 7/1/04.

**3. <u>Services Plan:</u>**

**a. Projected number of clients to be served in FY 2004 (7/1/2003 – 6/30/2004):**
- 161
- Percentage projected to be "literally homeless": 80%

**b. Specific services to be provided:**
NCSB Homeless Project (Norfolk PATH) is primarily an outreach and case management program for homeless persons with mental health disorders. Services

are provided in shelters, drop-in centers, soup kitchens, and on the streets. Street outreach may be conducted under bridges, in alleys, in wooded areas, or in any area where persons may be considered "hard to reach." Follow-up and case management services are primarily provided in two outreach offices (Union Mission Shelter and St. Columba Drop-in Center), at NEST during the winter, and at the mental health services center after an outreach relationship is established or if someone walks in. Shelters, homeless serving agencies, and public safety staff are periodically trained in the identification of PATH eligible persons and ongoing relations are kept to ensure that referrals to Norfolk PATH or requests for outreach are provided. In addition, MH Crisis staff and the emergency rooms make referrals to Norfolk PATH on a regular basis to assist PATH in follow-up of identified homeless PATH eligible persons encountering these service providers. Below is a list of all PATH eligible activities at NCSB.

- Outreach Services
- Screening and Diagnostic Treatment Services
- Community Mental Health Services
- Assessment for Substance Abuse Needs/Referrals to appropriate treatment
- Staff Training – agency as well as other homeless services providers
- Case Management
- Referrals for primary heath services, job training, educational services, and relevant housing services
- Housing Services – technical assistance, planning, improve coordination, matching costs, security deposits, and one-time rent.

**c. Key Services:**

Current Services:

- Norfolk Community Services Board: MH, MR, SA case management, treatment, psychiatric services, housing services including Shelter + Care, and psychosocial programs. —PATH worker employed at NCSB, works out of MH office, refers directly to NCSB services.
- Norfolk DSS/DHS: HART Team (homeless outreach and services team), food stamps, Medicaid, and adult services. —PATH worker coordinates with HART Team and may refer/share clients.
- Union Mission: Emergency shelter, transitional housing, permanent SRO type housing, meals, and outreach office for PATH. —PATH worker conducts outreach at Union Mission on a weekly basis, providing assessments, referrals, and case management.
- Salvation Army: Day drop-in services, employment services, voice mail, mailing address, laundry, shower, meals, limited emergency shelter, and transitional housing. —PATH worker conducts outreach at Salvation Army on a weekly basis, providing assessments, referrals, and case management.
- St. Columba Center: Day drop-in services, shower, laundry, phone, food, clothing, financial assistance for medical prescriptions, transitional housing, and outreach office for PATH. —PATH worker conducts outreach at St. Columba on a weekly basis, providing assessments, referrals, and case management.

- For Kids: Family emergency shelter, transitional housing, permanent supportive housing, aftercare services, and employment program. —PATH worker makes referrals to program.
- Barrett Haven: Transitional housing. —PATH worker makes referrals to program.
- Planning Council: Homeless Intervention and Prevention
- Veterans Outreach: Outreach and Case Management for Mentally Ill Veterans. —PATH worker coordinates with Veterans Outreach and may refer/share clients.
- YWCA: Emergency shelter/domestic violence, transitional housing/substance abuse recovery. —PATH worker makes referrals to program.
- NEST: Winter shelter and outreach site for PATH. —PATH worker conducts outreach at NEST on a weekly basis, providing assessments, referrals, and case management.
- Faith Community: 15 sites providing soup kitchen and pantry services. —PATH worker conducts outreach at St. Mary's Soup Kitchen on a weekly basis, providing assessments, referrals, and case management. Referrals to soup kitchens provided as well.

**d. Identified Gaps in Services (as identified by Continuum of Care 2004):**

Identified gaps remain the same this year according to the CofC 2003-2005 Strategic Priorities. Progress has been made on addressing gaps and will continue to be addressed throughout 2005.

1. Permanent Housing – max $400/month
2. Comprehensive Day Services – Families and single persons access to benefits, other agencies and services, daily hygiene, and daily living needs.
3. Emergency Shelter - Single persons
4. Residential Substance Abuse Services
5. Transitional Housing – 200 units – families and singles
6. Mental Health Services – Medication assistance, case management for non-SMI, and psychiatric care.
7. Comprehensive Case Management
8. Homeless Prevention Programs
9. Medical Prescriptions and Supplies
10. Legal Aid – One full time lawyer for non-criminal issues
11. Life Skills – Aftercare with vocational skills training, budgeting, and counseling for 1 year post shelter

**e. Services available for clients with Co-occurring Mental Illness and Substance Use Disorders:**

Norfolk PATH worker is experienced in the assessment of co-occurring disorders, having 10 years of experience working with clients who are homeless and have co-occurring disorders. Norfolk PATH provides an assessment of co-existing disorders and makes recommendations/referrals to NCSB MH intake, detox, SA residential intake, or to private provider for services to address the dual need. Norfolk PATH advocates with shelters to provide accommodations to those needing to attend day

treatment or night meetings for recovery work. Norfolk PATH also works closely with MH/SA case managers to ensure continuity of care from Norfolk PATH to the mainstream service.

**f. Strategies for Making Suitable Housing Available to PATH clients:**
Norfolk PATH worker identifies individuals who would be appropriate/eligible for, NCSB residential programs (MH or SA) and Shelter+Care. PATH worker provides a housing history and needs assessment to intake and follows up with assigned case manager. Norfolk PATH worker also completes applications for Shelter+Care and provides all necessary documentation and homelessness verifications. Norfolk PATH worker continues to work with community providers to assess needs and availability of rental housing, boarding homes, rooms for rent, board and care facilities, permanent housing facilities (811 and 202) and transitional housing. Historically the Norfolk PATH worker served on the committee to establish a SRO program in the area. The SRO program made its first application through the Norfolk Continuum of Care process last year and will make a second application this year. A plan for 60 regional SRO rooms is underway. The Norfolk CSB has a supportive housing program, Mental Health Residential Services (MHRS). PATH clients may be eligible for this housing; entry into this program is via referral from case management.

**4. Coordination with HUD CofC:**

Norfolk PATH worker is an active and participating member of the Norfolk Homeless Consortium (NHC), the CofC group for the city. Norfolk PATH worker serves on the Regional Chronic Homeless Committee, and participates in the coordination of the Point-in-time count.

**5. Cultural Competence:**

| Organizational profile of staff for race/ethnicity | Community Profile |
|---|---|
| 51% Black or African American | 45% |
| 45% White | 50% |
| 2.5% Native Hawaiian or Pacific islander | 0% |
| 1% Asian | 3% |
| <1% American Indian or Alaska Native | 0% |
| Other | 2% |

Race/ethnicity of PATH staff:
100% White (one staff person currently on staff)

Norfolk PATH worker has 10 years of experience working with diverse populations in the mental health and homeless communities. PATH worker also had intensive diversity training in BSW and MSW programs. Norfolk CSB core training curriculum includes consumer responsiveness, which is a course in cultural, disability, and ethnic diversities. Ongoing training of this nature is provided through Norfolk CSB to the PATH worker. The Norfolk PATH worker speaks conversational Spanish. The local Red Cross provides interpreters for other languages as needed. The regional deaf services

representative has worked closely with PATH to provide translation and co-case management assistance to homeless mentally ill deaf persons.

The Norfolk Homeless Consortium provides the annual needs assessment and recommendations for service providers. There is consumer representation in this group and consumers are recruited to participate in the annual gaps analysis and to make service recommendations. Historically, the Norfolk PATH worker has had contact with two persons who are graduates of homeless programs. One is a former NCSB client who volunteers to do community trainings with PATH and reviews proposals made by PATH and the Homeless Consortium for planned services.

**6. <u>Consumer/Family Involvement:</u>**

The Norfolk Community Services Board has a Board of Directors comprised of fifteen persons. Consumers and family members are represented on this Board. Community forums are an ongoing service of the NCSB. The NCSB employs a Consumer Relations/Client Rights Advocate. Ongoing surveying of clients and services is conducted.

The Norfolk Homeless Consortium provides the annual needs assessment and recommendations for service providers. There is consumer representation in this group and consumers are recruited to participate in the annual gaps analysis and to make service recommendations. Historically, the Norfolk PATH worker has had contact with two persons who are graduates of homeless programs. One is a former NCSB client who volunteers to do community trainings with PATH and reviews proposals made by PATH and the Homeless Consortium for planned services.

Historically, Norfolk PATH has attended Norfolk Alliance for the Mentally Ill meetings as requested and has provided a link to this community of family members through the coordinator of this group. Homeless persons and their family members are provided cards to complete to submit comments on services anonymously. The organization also holds “town hall” meetings for consumers and families as well as one for other providers to comment on all NSCB services. All services provided by PATH worker are performed with the consumer’s involvement and their families (if available) are involved based on the consumer’s preference.

Clients are informed of services available and may or may not choose to participate. Client rights are respected and enforced by agency policy.

It is the intention of the PATH Program to create a Consumer Satisfaction Survey for those NCSB clients involved in the PATH program. This survey will be conducted two times a year over a period of one week in which clients will be asked to provide feedback on PATH Services.

**Budget Form** Norfolk CSB FFY04 / SFY05

| Category | | | PATH Funded Amount | Non-Federal Direct Match | Source of Match Cash or In-Kind *( delete one)* |
|---|---|---|---|---|---|
| **Staff Title** | **Annual Salary** | **FTE** | | | |
| Case Manager III | [redacted] | [redacted] | [redacted] | | |
| Case Manager I | [redacted] | [redacted] | [redacted] | | |
| Supervisor | [redacted] | [redacted] | | [redacted] | In-Kind |
| | | | | | |
| | | | | | |
| | | | | | |
| **TOTAL PERSONNEL** | | | [redacted] | [redacted] | |
| **TOTAL FRINGE BENEFITS** | | | [redacted] | [redacted] | |
| **Travel** e.g.: Outreach, or travel to training, or travel to state meetings | | | | | |
| | | | $[redacted] | $ | |
| | | | $ | $ | |
| | | | $ | $ | |
| **Equipment** List individually any non-expendable, tangible personal property having a useful life of more than one year. | | | | | |
| | | | $0 | $ | |
| | | | $ | $ | |
| | | | $ | $ | |
| **Supplies** e.g.: Program Supplies or Computer Software | | | | | |
| | | | [redacted] | [redacted] | cash |
| | | | $ | $ | |
| | | | $ | $ | |
| **Contractual** If more contracted services, attach an additional sheet with description. | | | | | |
| | | | $ | $ | |
| | | | $ | $ | |
| **Other** Describe any other proposed expenditures | | | | | |
| Space and related expenses; insurance, office supplies; vehicle usage, etc | | | [redacted] | [redacted] | In-Kind |
| | | | $ | $ | |
| | | | **PATH** | **Match** | |
| **Total PATH Budget** | | | $76,456 | $25,230 | |

Note: The PATH budget period runs from 9/1/04 through 8/31/05, even though the reporting period runs from 7/1/04 through 6/30/05.

You will be paid from the current PATH budget for July and August 2004.

NORTHWESTERN COMMUNITY SERVICES

## PATH APPLICATION

**1. Provider Organization:** (name and type) Northwestern Community Services (NWCS) is a non-profit community mental health center.

Description of services: NWCS provides outpatient counseling and emergency services for adults, families, and children with mental health, mental retardation, and substance abuse issues; psychosocial day treatment programs through 2 clubhouses and housing assistance through the community living program;
Parent-Infant Education services for children with developmental delays, age birth to 3 years; Women's Intensive Outpatient program; services for the homeless with disabilities through PATH, SHP, and S+C; programs for children with mental health and substance abuse issues through In-Home Services, Mentoring Services and School Base Services.

Region Served: City of Winchester and the counties of Clarke, Frederick, Page, Shenandoah, and Warren.

**2. PATH Funds:** NWCS will receive $21,083 PATH funds.
The source of PATH match comes from liability insurance and mental health/substance abuse services provided by NWCS. The in-kind match will be available on July 1, 2004.

PATH funds will be used for the following:
Case manager (outreach staff) and fringe benefits: provides outreach, screening, case management, and other supportive services.
Travel: staff travel to outreach sites and training sites.
Supplies: General program operating supplies and computer software upgrades for PATH participant records, services, quarterly and annual reports, and integration with the continuum of care.
Housing rental assistance: Payments of security deposits and/or one-time rental payments.
Program administration: processing and review of program funds, quarterly/annual reports, leases and checks to landlords, and staff administration.
Office space: Houses PATH participant case files, provides space for interviewing participants, staff processing of PATH reports and other administrative functions.
The office space is located in the same building with a realtor and Northwestern Community Services MH/SA clinic enabling PATH participants to be easily engaged in needed services such as MH/SA and housing.

**3. Services Plan**:

a. Projected number of clients who will receive PATH funded services for FY 2005 will be **123.** 90% of these clients are projected to be "literally homeless" (outdoors or in emergency shelters).

b. List and describe how specific services are to be provided fully or partially using federal PATH funds.

**Outreach is directly provided by staff to local shelters, the street, and other organizations. Routine screening times are provided by schedule in advance to enhance outreach and screen shelter populations.

**Screening and diagnostic treatment is provided by the case manager for selected individuals. Arrangements are made for more comprehensive diagnostic services through the Clubhouse case manager or through the mental health clinic.

**Community mental health services are arranged by PATH for provision through the Mental Health clinics and psychosocial rehabilitation staff.

**Substance abuse (alcohol or drug) treatment services are arranged by PATH for provision through the Mental Health clinics and by referral to other agency providers.

**The PATH coordinator provides staff training to staff members and other service providers working in shelters, mental health clinics, and other sites where homeless individuals require services. PATH coordinator attends related trainings and the Clinical Director provides additional training.

**Case management is provided following outreach contact and eligibility determination. PATH case management provides intensive coordination to meet the needs of the participant and also provides assistance with permanent housing, and referrals to mainstream health and social services, assistance with financial planning, transportation, job training, and employment services.

**Supportive services within residential settings are provided by PATH and other agency residential program staff provides longer-term support.

**Housing services assists the participant in locating housing, making application for housing, and moving into housing. Payments of security deposits are made to enable the participant to secure permanent housing and one-time rental payments are made to prevent eviction of a PATH participant.

c. Community organizations that provide key services:
The Northern Shenandoah Valley Homeless Network (Continuum of Care) consists of organizations throughout the planning district that provide key services to PATH eligible clients. The PATH Coordinator chairs the monthly meetings of these organizations, which provide permanent housing, mainstream health and social services resources, mental health, substance abuse services, job training, employment, and other specific needs of the homeless. A PATH eligible client can enter any organization within the continuum of care and receive services through referral and direct service contact.

Major providers that cover the range of services available to clients are as follows: Northwestern Community Services, Starting Point Detox, Free Medical Clinic, CCAP, Salvation Army, Rescue

Mission, Department of Rehabilitation, Shelter for Abused Women, Edgehill, Access Independence, Aids Response Effort, NW Works, Social Services, Concern Hotline, Healthy Families, Winchester Migrant Program, Shenandoah Alliance for Shelter, the ARC, Winchester Medical Center, Consumer Credit Counseling, Welfare-To-Work Program, Department of Rehabilitation Services, Lord Fairfax Council on Alcoholism, and landlords throughout the planning district.

d. Gaps in the current service system:
Gaps in the current service system are as follows: The list for Housing Choice Vouchers (Section 8) is currently closed and persons on the list have to wait for several years before there is an opening; not enough space in the emergency shelters, limited transitional housing, and in some areas shelters do not exist;
lack of adequate transportation services; high cost of medications; access to mainstream social and health services (SSI, Medicaid, food stamps, health care,
and job training/employment). Lack of payee services for those in need of assistance managing money to ensure rent and utilities are paid.

e. Services available participants with co-occurring MH/SA:
The special needs of co-occurring mental health and substance abuse disorders are addressed through the services of the Supportive Housing Program and the Shelter Plus Care program through outreach, diagnostic screening, assessment, case management, and referral as needed. Consumers with co-occurring MH/SA disorders have been identified as a priority population of Northwestern Community Services. Specialized training opportunities have been made available to the Path Coordinator and to other service providers. PATH participants are linked to these services through referral from within NWCS and through other service providers.

f. Strategies for making suitable housing available to PATH participants:
The community plan is based on outreach and referral by service providers and the PATH staff. The PATH staff will provide guidance and counseling on all issues of housing for eligible participants. Suitable housing for PATH participants will be provided through application for Housing Choice Vouchers (Section 8 housing), through services offered by the Supportive Housing Program, Shelter Plus Care program, realtors, and landlords throughout the Planning District. Staff will accompany participants, as needed, to ensure they understand the process in completing applications, lease agreements, connecting to utilities and all other administrative requirements.

**4. Coordination with HUD CoC:** Coordination between local PATH providers and the HUD Continuum of Care and other similar programs is accomplished through monthly meetings of the Northern Shenandoah Valley Homeless Network, and through outreach, screening, case management, and referrals involving the Supportive Housing Program, Shelter Plus Care Program and other community based programs throughout the planning district. This system of coordination enables participants to enter the continuum of care at any point and be fully integrated into all available services.

**5. Cultural Competence:**
NWCS organization profile of staff for race/ethnicity:
206 (96%)white; 7 (3%)black; 1 (<1%)Hispanic; 1 (<1%)Asian=215
Path staff race/ethnicity: 1 (code 6-white)
Community profile for race/ethnicity:
94% white, 4% black, 2%Hispanic (of total), 1% Asian, and 2%Other

The PATH staff has extensive background in social work, counseling with formal course work in age, gender, and racial/ethnic differences. The staff also has human services work experience with participants of all ages, racial and ethnic backgrounds, and gender differences. The staff does make themselves available to local workshops and seminars regarding age, gender, and racial/ethnic cultures and backgrounds. Also, NWCS has an internal Cultural Diversity Committee sponsoring workshops and internal training for staff. The PATH coordinator also has prior experience in presenting formal classroom training on cultural differences.

**6. Consumer/Family Involvement:** Homeless consumers, mental health consumers, and family members attend the initial screening and attend each step in the process regarding the development, implementation, and review of service plans, referrals to mental health/substance abuse services, other health or social services, and housing location and application. They also participate with the Continuum of Care, Northern Shenandoah Valley Homeless Network, identifying community needs, goals, and objectives, grant application/budget development. They participate in the development of program evaluations and satisfaction surveys distributed to consumers and family members for agency-wide and PATH funded services.

NORTHWESTERN COMMUNITY SERVICES
PATH BUDGET FFY04 / SFY05

| Category | | | PATH Funded | Non-Federal Direct Match | Source of Match |
|---|---|---|---|---|---|
| Staff Title | Annual Salary | FTE | | | Cash/In-Kind |
| | | | | | |
| Case Manager: | [redacted] | [redacted] | [redacted] | | |
| (Outreach Staff) | | | | | |
| TOTAL PERSONNEL | | | [redacted] | | |
| TOTAL FRINGE BENEFITS | | | [redacted] | | |
| | | | | | |
| **Travel:** (Staff travel to | | | [redacted] | | |
| outreach sites and training) | | | | | |
| Equipment: | | | | | |
| | | | | | |
| **Supplies:** | | | | | |
| Program Supplies | | | [redacted] | | |
| Computer Software | | | [redacted] | | |
| **Other:** | | | | | |
| Housing-Rental Assistance | | | [redacted] | | |
| Program Administration | | | [redacted] | | |
| Office Space | | | | | |
| Liability Insurance | | | | [redacted] | In-Kind |
| Mental Health/ Substance Abuse Services | | | | [redacted] | In-Kind |
| TOTAL PATH BUDGET | | | $21,083 | $7,028 | |

*FY 2005 PATH Application: Local Provider Intended Use Plan*

1. **Provider Organization**

   The name of PATH providing organization is: **on our own, charlottesville**, va., inc. It is a consumer-run Drop-In Center serving the Thomas Jefferson Planning District (City of Charlottesville, counties of Albemarle, Green, Nelson, Fluvanna, and Louisa).

2. **PATH Funds**

   on our own, charlottesville, va., inc., will receive $23,525 for FY 2005. PATH funds will be expended in the following manner: $[redacted] for 0.5 FTE Outreach Worker; $[redacted] for 0.2 FTE Executive Director (who provides many of the same services as the Outreach Worker); $[redacted] for fringe benefits ($[redacted] – employer taxes, $[redacted] – health insurance, $[redacted] – worker's comp.), and $[redacted] for program supplies/outreach activities. Non-federal direct match funds will be expended as follows: $[redacted] for program supplies/outreach activities; and $[redacted] for other ($[redacted] – rent, phone, utilities, $[redacted] – vehicle maintenance and insurance). The matched funds will be available at the beginning of the grant period. Matched funds will be provided by the Virginia Department of Mental Health Mental Retardation and Substance Abuse Services (DMHMRSAS), Virginia Department of Housing and Community Development (DHCD), and cash fundraised through our fundraising efforts.

3. **Services Plan**

   a. The projected number of clients to be served by PATH in FY 2004 is 175. The percentage of these clients projected to be "literally homeless" is approximately 90%.

   b. Specific services provided by PATH staff include: outreach services; referral to community mental health and alcohol/drug treatment services, primary health services, job training, educational services, and housing services; educational training to consumers as well as local community agencies as to the PATH program; case management services; supportive and supervisory services in residential settings; and housing services including planning, application and technical assistance, and improving coordination of housing services.

   c. Community organizations that provide key services to PATH eligible clients in our area include: University of Virginia Health Sciences Center, The Salvation Army, Monticello Area Community Action Agency (MACAA), On Our Own, AIDS Services Group, Region Ten Community Services Board (CSB), Shelter for Help in Emergency (SHE), Sexual Assault Resource Agency (SARA), Charlottesville Redevelopment and Housing Authority, Piedmont Housing Alliance, Western State Hospital, Thomas Jefferson Area Coalition for the Homeless (TJACH), Charlottesville Public Housing Association of Residents (PHAR), and the Virginia Employment Commission. The University of Virginia Health Sciences Center accepts indigent patients for medical problems and provides in-patient psychiatric care. Both of the hospital's psychiatric units are aware of On Our Own and works with us to coordinate admission, patient care, and after care pertaining to housing and mental health services. The Salvation Army has an emergency shelter as well as a social services department. On Our Own has almost daily contact with one portion of the Salvation Army or another. Services coordinated include: emergency and transitional housing, procurement and payment of medications, case management, and various other needs as they arise. Region Ten CSB is our local mental

health agency. On Our Own works with Region Ten on a daily basis in coordinating support services (through our collaborative Partnership for Assertive Community Support Services), transitional and permanent housing, crisis services (including stabilization), intake and access, PATH, and liaising with Western State Hospital. PHAR provides assistance with advocating for affordable housing and also with employment through its Connecting People to Jobs program (which was recently restarted and has been of tremendous value in the community). We also coordinate services through a myriad of local non-profit organizations including: MACAA (transitional housing for homeless families), AIDS Services Groups (AIDS services), SARA (sexual assault resources), SHE (domestic violence), Piedmont Housing Alliance (advocating for affordable housing), and others.

d. Gaps in our current service system include: affordable housing, supported transitional housing, support services for homeless individuals (especially those without insurance), adequate emergency shelter, substance abuse services including detox and longer programs, dual diagnosis services, and timely mental health services.
e. Persons with co-occurring mental illness and substance use disorders go through the same procedure as far as receiving services through Region Ten. Individuals are educated as to the resources available in the area and are assisted with accessing them. On Our Own provides an up-to-date listing of AA and NA meetings as well as offering peer support by staff and members in recovery.
f. Region Ten operates the Dual Recovery Center (DRC) designed specifically for dually diagnosed individuals (mental health/substance abuse). DRC offers support services and permanent housing in Region Ten owned/leased properties throughout the City of Charlottesville. On Our Own continues to collaborate with already established landlords to provide rooms on a short-term basis until more permanent housing becomes available. For those who qualify, the Transitional Housing program at On Our Own (which can house a maximum of three) is also used. To work on more permanent housing, we have spoken with/presented our programs to the housing authorities in our region along with attending housing meetings at Region Ten CSB. We continually work to build new alliances with landlords that will work with clients enrolled in our PATH program. A new program which assists is Region Ten's recent award of the Shelter Plus Care program. PATH clients are eligible to participate in this program.

**4. <u>Coordination with HUD CoC</u>**

As mentioned above, On Our Own works closely with the other local PATH provider, Region Ten CSB. Both providers meet weekly and coordinates services as appropriate. On Our Own also attends and participates in the Thomas Jefferson Area Coalition for the Homeless (TJACH), whose charge it is to develop the local continuum of care. TJACH has been vital in spreading the word about homelessness in our region and gathers and maintains statistics. New programs have been proposed to address the needs of the mentally ill and homeless in the area and have been received. Because On Our Own has been a participant in homeless activities throughout our existence, we are often called upon to make statements in our local newspapers and to participate in local homeless forums. On Our Own also provides technical assistance and education to any person or group learning about homelessness in our region.

## 5. & 6. Cultural Competence and Consumer/Family Involvement

On Our Own currently employs six staff, two of which are full-time. At present, all staff are Caucasian. The community is 81% Caucasian, 15% Black/African American, 2% Asian, 2% other, and an overall Hispanic population of 2%.

On Our Own is a consumer-run organization, hence, everything that On Our Own does takes into consideration the needs of the people it serves through the history of those who provide its services. Our focus is always on the involvement of each person who receives services in their own treatment. We offer a true partnership model of service delivery which utilizes the strengths of the recipients rather than looking at just their pathology. A majority of On Our Own management, including the board of directors and the executive director, are mental health consumers – many having experienced homelessness. Our staff consists of a wide cross-section of individuals who have experienced many of the indignities and injustices On Our Own addresses. On Our Own also asks for consumer involvement through house/member meetings and an open door policy concerning decisions affecting the center. On Our Own has a policy of non-discrimination and aims to employ individuals who have the characteristics of the individuals we serve. Training continues on an on-going basis through in-depth talks with our clients, each other, other service providers, and the state human rights policy.

# On Our Own FFY04 / SFY05 Budget Form

| Category | | | PATH Funded Amount | Non-Federal Direct Match | Source of Match Cash or In-Kind *( delete one)* |
|---|---|---|---|---|---|
| **Staff Title** | **Annual Salary** | **FTE** | | | |
| *e.g.: Outreach Staff* | *$28,000,* | *0.5* | *$10,000* | *4,000* | *Cash* |
| Outreach Staff | [redacted] | [redacted] | [redacted] | | |
| Executive Director | [redacted] | [redacted] | [redacted] | | |
| | | | | | |
| | | | | | |
| | | | | | |
| **TOTAL PERSONNEL** | | | [redacted] | $ | |
| **TOTAL FRINGE BENEFITS** | | | [redacted] | $ | |
| **Travel** *e.g.: Outreach, or travel to training, or travel to state meetings* | | | | | |
| | | | $ | $ | |
| | | | $ | $ | |
| | | | $ | $ | |
| **Equipment** *List individually any non-expendable, tangible personal property having a useful life of more than one year.* | | | | | |
| | | | $ | $ | |
| | | | $ | $ | |
| | | | $ | $ | |
| **Supplies** *e.g.: Program Supplies or Computer Software* | | | | | |
| Program Supplies/Outreach Activies | | | [redacted] | [redacted] | In-Kind |
| | | | $ | $ | |
| | | | $ | $ | |
| **Contractual** *If more contracted services, attach an additional sheet with description.* | | | | | |
| | | | $ | $ | |
| | | | $ | $ | |
| **Other** *Describe any other proposed expenditures* | | | | | |
| Rent, phone, utilities | | | [redacted] | [redacted] | In-Kind |
| Vehicle | | | [redacted] | [redacted] | In-Kind |
| | | | **PATH** | **Match** | |
| **Total PATH Budget** | | | $23,525 | $7,842 | |

PATH SFY04-05 INTENDED USE PLAN

PORTSMOUTH DEPARTMENT OF BEHAVIORAL HEALTHCARE SERVICES
REGION SERVED: CITY OF PORTSMOUTH

**1. Organization:**

The Portsmouth Department of Behavioral Healthcare Services provides mental health, mental retardation and substance abuse services to the citizens of the City of Portsmouth.
Theses services include 24 emergency services, outpatient treatment for mental health and substance abuse, case management services, supportive and supervisory residential services and crisis case management.

**2. PATH Funds:**

$52,668 in Federal PATH funds. Match will be available on 7/1/04.
PATH funds cover the [redacted] of two FTE Case Managers. The remaining expenses for homeless services are funded with state general fund dollars.

**3. Service Plan:**

The Portsmouth Department of Behavioral Healthcare Services currently has two full time case managers providing services to homeless persons who also have a serious mental illness.

a. Projected number of clients who will receive PATH funded services in FY 05- 336. 80% are projected to be "literally homeless" (outdoors or in emergency shelters)
b. Services are provided by two case managers who provide outreach and assessments at three locations within the city (homeless case management office, central access, and Oasis Opportunity Center). Clients are assessed to determine what services are needed before making the appropriate referrals. Mental health, mental retardation, and substance abuse services are provided by DBHS, but are not supported with PATH funds.
c. Community organizations that provide key services to PATH eligible clients include the following: Portsmouth Volunteers for the Homeless (winter church shelters), Oasis Social Ministries (food, clothing, medication vouchers), Tidewater Aids Crisis Center (case management services for PWA, housing, med referrals), Oasis Opportunity Center (housing, case management, training), Urban League (financial assistance), St. Columbia Ministries ( substance abuse services, housing, case management), Second Chances (services for ex-offenders), Salvation Army/Union Mission (short or long term housing, job placement, counseling, AA meetings), Wesley Center/Child and Family Services (payee services) Zion Baptist Church (meals, showers) Dept of Social Services ( food stamps, entitlements)
d. Gaps: Because of the continued lack of adequate funding we continue to lack the resources to meet the demand for services. Affordable housing continues to be the major problem in this area. Barriers to finding housing continue to be poor credit or criminal history, outstanding utility bills, income requirements. With assistance our clients can usually access other resources without encountering a waiting lists. The section 8 housing waiting list is currently about 36 months, shelter plus care at least 60 days.
e. Services available for clients with co-occurring mental health and substance abuse disorders: Following an intake assessment these clients are referred to our department's

substance abuse program for evaluation and orientation into the services which may include case management, medication management, opiate replacement, drug court, and outpatient services.

f. Strategies for making suitable housing available to PATH clients include assessing the client for eligibility for either the Shelter Plus Care program or the Single Adult Barrier Reduction Exchange program (SABRE). The Portsmouth Area Resource Coalition (PARC) also has a transitional housing program for persons who are homeless and disabled. Depending on the needs and resources of the client, they may also be referred to the Union Mission or the Salvation Army for housing, however placement for the agencies may occur in another city.

**Coordination with HUD CoC:** Our agency as well as representatives from the City of Portsmouth are members of the Portsmouth Homeless Alliance Consortium, which is our CoC. Our department works collaboratively with several agencies throughout the city in our efforts to secure funding for homeless initiatives in the city. A staff person from DBHS is currently the chairperson of the consortium.

**Cultural Competence:** The organizational profile of staff for race/ethnicity for DBHS consists of the following: White—male-10 (9%), female-15 (13%) total-25 (22%)
Black—male-16 (14%) female-66 (59%) Hispanic—male-1 (%) female-1 (1%)
Asian/Pacific Islander-male-2 (2%) female-1 (1%)
PATH STAFF-2 females- 1 Black, 1 White
Community profile: White 47%, Black 51%, Asian/Pacific Islander 1%, Other 1%, and of the total 2% report to be Hispanic.
The PATH staff has extensive experience working with a diversity of homeless persons in the city. Through the agencies association with the IAPSRS (International Association of Psychosocial Rehabilitation Services) staff are knowledgeable about multicultural principles and practices. The agency has a goal to provide training in cultural competence in its strategic plan.

**Consumer/Family Involvement:** The Department of Behavioral Healthcare has conducted community forums to receive input from consumers, family members, agencies, and citizens regarding the services provided by the agency. Comments and suggestions from these forums were used to develop the agencies strategic plan. The mission statement of our agency is The Portsmouth Department of Behavioral Healthcare Services provides mental health, mental retardation, substance abuse, prevention, treatment and support services that: are consumer and family focused and community based; provide choice, involvement and diversity; maximize full integration into community life in the least restrictive environment; are accessible, coordinated and comprehensive. The agency currently has two consumers on its advisory board.

Portsmouth Budget FFY04 / SFY05

| Category | | | PATH Funded Amount | Non-Federal Direct Match | Source of Match (Enter Cash or InKind) |
|---|---|---|---|---|---|
| **Title** | **Annual Salary** | **FTE** | | | |
| Case Manager | | 2 | | | Cash |
| Program Administrator | | 0.25 | | | Cash |
| **TOTAL PERSONNEL** | | 2.25 | | | |
| **TOTAL FRINGE BENEFITS** | | | $ | | |
| | | | | | |
| **Travel** | | | | | |
| *Outreach* | | | | | |
| *Travel to Training, Workshops, State meetings* | | | | | Cash |
| | | | | | |
| **Equipment*** *List Individually (Equipment means a non-expendable, tangible personal property having a useful life of* | | | | | |
| | | | | | |
| | | | | | |
| **Supplies** | | | | | |
| *Program Supplies* | | | | | Cash/in-kind |
| *Computer Software* | | | | | |
| | | | | | |
| **Contractual*** | | | | | |
| | | | | | |
| **Housing** *List (e.g." One-time Rental Assistance")* (must be *<20% of PATH Total budget* ) | | | | | |
| Rent | | | | | Cash/in-kind |
| | | | | | |
| | | | | | |
| **Other** *(list, e.g. Vehicle Maintenance, etc)* | | | | | |
| Vehicle maintenance | | | | | Cash/in-kind |
| | | | | | |
| | | | | | |
| **Non-Program Administration** | | | $XXXX | | |
| **Grand Total** | | | $ 52,668.00 | $ 35,996.00 | $ 88,664.00 |
| | | | PATH Funds | Match | Total Program |

**Provider Organization:**

The **Prince William County Community Services Board** is the umbrella agency for the area Path program and offers a variety of mental health, mental retardation, substance abuse, and early intervention programs as well as emergency services for the citizens of Prince William County, and the Cities of Manassas and Manassas Park. The PATH program works under the MH Residential Program, in the unit that provides intensive case management, outreach and supportive services.

**PATH Funds:**

Prince William County CSB will receive $32,451.00 and an incentive award of $5,727.00 for a total of $38,178.00. The CSB will provide the matching funds of $17,529.00, in salary, fringe benefits, and other position needs for the PATH program. These funds will be available on July 1, 2004 for use of this program.

Budget line item narrative:

1. To hire 0.59 FTE position as a PATH therapist. This equals 22 hours per week.
2. To hire one or two therapist II staff at the base rate of $[redacted]/hour, to act as back up for 12.5 hours per week for 10 weeks while the outreach therapist is on maternity leave (anticipated within this fiscal year).
3. 0.16 (6 hours per week) of the PATH supervisor's salary as match. This time is the actual PATH clinical time, including supervision of the PATH therapist and back-up staff hired to serve as PATH therapists.
4. Travel for the PATH therapist and back-up PATH therapists accrued while providing PATH services.
5. The licensing fees for 2 HMIS licenses. The local Homeless Services Network Council chose the Bowmen Service Point system as the HMIS.
6. Cell phone charges for the PATH therapist's agency provided cell phone, at the rate of $[redacted] per month for 12 months.
7. Client concrete service. These are costs for items and food provided directly to PATH clients. This includes for example: bus tokens, tents, fees for birth certificates to be able to obtain identification and food.
8. The share of the cost of the office rental for the PATH therapist.
9. Trainings and Conferences. The agency provides a $[redacted] match, and the PATH grant provides $[redacted]. This is the cost of travel, food, lodging and the fee for training or conferences.

**Services Plan:**

a. Projected number of clients who will receive PATH funded services?:
The Federal portion of the PATH clients we serve will be 166, of these consumers 90% of them are anticipated as literally homeless.

b. List and describe how specific PATH services will be provided:
The award will allow Prince William County CSB to retain a Therapist II, half-time (twenty-two hours a week) to provide outreach services in emergency shelters, overflow units, the Winter Shelter, (hypothermia shelter), the Drop-In-Center, and on the street or occasionally at campsites in the woods; case management (monitoring, directly assessing,

linking to community services, including substance abuse treatment, both verbally and taking client to the needed service, including housing, mental health, substance abuse services, job placement assistance, medical services, and entitlements as well as coordinating with the referral agencies, and advocating for client's needs); concrete funds for security deposits; costs associated with matching homeless individuals with appropriate housing which PATH currently provides through ordinary means such as newspapers and housing lists provided by the local shelter, and also through word of mouth and linking to the assistance of faith based organizations; and rental assistance to seriously mentally ill and/or dually diagnosed individuals who require, but have not yet engaged in receiving, such services. In addition, the PATH Therapist and the PATH supervisor liaison with the local shelters, providing consultation and training to shelter staff, Drop-In-Center staff, and volunteers.

c. Coordination with community services: The PATH staff work closely with community providers to assist clients. Primary health care is provided at the two local hospitals (primarily ER) one located in Eastern PWC and the other in Western PWC, the PWC Health Department Walk-In Clinics also with two sites on both sides of the county and the Potomac Hospital Family Health Care Vans. The vans are the best and primary sources of medical support for the PATH consumers. They are located in Eastern PWC, but will see homeless from both ends of the county. Through an agreement with the health care vans, the local Department of Social Services and the PATH program, the vans now provide health care at the Winter Shelter/Drop-In-Center site. The program has a good working relationship with Potomac Hospital. On the Western end of PWC the Serve Shelter has a good relationship with several local Doctors and the Health Department's Walk-In Clinic, and the PATH worker coordinates with these agencies directly and through the shelter. Mental Health (MH) and Substance Abuse (SA) treatment are primarily provided through the CSB. Since PATH is also coordinated through the CSB this works well. The federally funded PATH therapist is based in one office site, and her supervisor who also provides PATH services is based out of the other CSB site. Both therapists work closely with the intake therapist, Emergency services staff, the Family Support staff and adult substance abuse services. Consequently the PATH therapists are able to obtain services, and are savvy about which services best suit the client, once the PATH client is open to accepting a referral for MH or SA services. The Prince William CSB does not have a residential substance abuse rehabilitation program or medical detox beds, and so must refer out to various treatment facilities such as Boxwood in Culpepper, VA, Serenity Home in Fredricksburg, VA and The Salvation Army in Alexandria, VA. These programs accept dually diagnosed clients. Social detox is provided through CSB Emergency Services and the Substance Abuse program. However, for medical detox the PATH client is referred to local psychiatric units such at Prince William Hospital's Center for Psychiatric and Addictions Treatment (CPAT) or Potomac Hospital's Behavioral Health Unit, which must be willing to take the PATH client on as an "indigent" client, as few have the finances or insurance. This requires a close relationship with these providers, and sometimes the relationship is with the CSB provider, who intern has a good relationship with the detox or treatment program. Housing is expensive and difficult to find in the Prince William County Area. Often the

first step in obtaining housing for the PATH client is to go to an emergency Shelter, SERVE INC., Volunteers of America-Chesapeake, and ACTS, or in the winter the Hypothermia Unit/Winter Shelter. The PATH counselor works very closely with the staff at all these shelters, providing consultation, MH services, training and as a liaison from the CSB. The shelter staff are more comfortable with taking clients when they have a PATH staff to follow the client, as the PATH worker comes out to the client, rather than requiring the client to come to the CSB office. The PATH staff work closely with the Drop-In-Center and Churches, such as St. Paul's Methodist and Vineyard Church to assist PATH client's to find and obtain housing. This is usually a joint effort, and often involves all of the resources available. The most common way to find housing is through word of mouth, and so each of the services providers share the information among themselves. The Cooperative Council of Ministries (CCOM) who coordinate the Drop-In-Center, have plans to develop a system of matching consumers to housing, but have not yet completed the process. The Volunteers of America Chesapeake Shelter has a transitional housing program for four men who have substance abuse issues and may be dually diagnosed. The CSB Residential Program (RP) has transitional housing for CSB clients with a serious mental illness. The CSB also provides Mental health treatment and support services to clients who live in the Community Apartments (which came out of a HUD 811 grant), coordinating with a management agency, Amercon, to manage the facility. The CSB RP also partners with The Good Shepherd Housing Foundation to provide permanent supportive housing, for homeless and non-homeless consumers. Employment supports for PATH clients are provided through the Department of Rehabilitative Services (DRS), the Supportive employment program (a combination of DRS and PWC CSB), the WAGES (Wings and Glory Employment Services) program through St. Paul's United Methodist Church, the employment counselor at SERVE INC. (a local Emergency Shelter/Emergency Assistance Program). In addition, many of the PATH consumers work with day labor employers. If the PATH client is able to work, and is able to manage the structure required for working with agencies, the PATH therapist coordinates with the organization. This is done through referrals, phone contacts and face-to-face, accompanying consumers to meetings. The agency DRS, SEP, SERVE or WAGES relies on the PATH counselor to fill in the gaps that the mainstream service cannot cover. The PATH counselor generally does not act as a job coach, but will help with coordinating transportation, provide bus tokens (after teaching how to use local transportation) and work with the client on managing their symptoms in various settings, including making least harmful choices about substance use.

d. Gaps: The primary gap for this area is affordable housing. This issue runs through all the different homeless groups from chronic to victims of domestic violence to those who do not make a living wage. The area does not have any SROs, Safe Havens, and no Housing First programs (although the PATH program will be presenting a proposal to the Continuum of Care for a Housing First program with some requirements for the consumer). The only transitional housing focused on this population is the Men's transitional program, for men with a history of substance abuse who may be dually diagnosed. The CSB Residential Program provides transitional housing and supportive services to 122 clients who have a serious mental illness. These programs have a good

deal of structure, and most PATH clients will not meet criteria for admission.
Entitlements: The agencies that review the disability reports, DDS and the VA, have become easier to access and work with as we have been learning how to work with them more effectively. The issue continues to be the length of time it takes to process, and at times, appeal the determinations. The other part of this issue is supports for people while they are within the process, most emergency shelters will not allow a six months stay, while the application is initially reviewed. When a client has a serious mental illness, and also has a medical condition that is disabling, it can be very serious. Finding housing, a strong medical response while waiting for the determination is virtually impossible. Because there are no SROs, Safe Havens or Housing First programs in this community.
Detoxification Programs: This community does not have a structured social detox program. The service is provided through the CSB Emergency Services, CSB outpatient Substance Abuse treatment, and various outpatient therapists. There are 2 inpatient "indigent" medical detox beds provided by local hospitals, the county has purchased up to four beds in the past, but due to funding cuts, these were eliminated. The lack of medical detox beds creates pressure on the local emergency rooms and EMS system responding to crisis situations that occur, when people who are at risk detox without medical supervision. In addition this situation frustrates medical staff, and makes it more difficult to work closely. Closely related to this is the potential gap that will likely occur when Potomac Hospital's Behavioral Health Unit and their day-treatment program closes this summer. It is unclear at this time the extent of the impact from this decrease in services in this community; and how this will be managed, as well as, the effect on the PATH consumers.

e. Services for clients who have co-occurring MH and SA disorders.: The PATH therapist is an employee of the CSB, and consequently has the ability to work closely with both mental health services and substance abuse services. Frequently because the PATH client is often in crisis if they are willing to obtain treatment, the PATH therapist works with the CSB Emergency Services program. These services are provided primarily through the CSB, this is generally because of funding/cost issues; especially because the CSB is able to partially subsidized treatment. PATH clients are also referred to the Alexandria Salvation Army program and the VA for substance abuse treatment. When this occurs, which is not often, the PATH worker coordinates on the transportation to and from the program and assists in providing discharge planning. At times, the PATH client who requires both MH and SA treatment is not in crisis, at those times the client can be referred to AA/NA groups, several of these self-help groups are held in the local VOA-Chesapeake Emergency Shelter. The CSB clinic located in Eastern PWC also has a group specifically for dually diagnosed clients, and if the PATH client has been willing to open a file with the CSB, then they are eligible for this group. In general, the CSB hires or trains staff to work with dually diagnosed consumers in an out patient setting. Those clients who have a mental health therapist/case manager, who would benefit by attending substance abuse groups, are able to attend cross-program and vice versa.

f. Strategies for making suitable housing available for PATH clients.: The PATH staff support and coordinate with other homeless services programs (emergency shelters,

Drop-In-Center, churches and the Aftershare program which provides outreach supports to those who are not in a shelter and are living on the street or in the woods or have completed shelter stays and continue to require supports) who are involved with referrals, word of mouth, finding financial supports for individual consumers and developing resources. This is done on a programmatically and individual case manager level. The PATH program refers, advocates and coordinates with the CSB Residential Program for PATH consumers. Including continuing to stay involved with the client while they develop a relationship with their therapist/case manager. The PATH program proposes and when appropriate attempts to find financial support for housing programs for people who have a serious mental illness and are homeless.

**Coordination with HUD Continuum of Care:**

The CSB has been involved with the Continuum of Care (C of C) prior to the inception of the PATH program in the PW Area. The PATH program supervisor has sat on the C of C since 1999. The C of C is a committee of the Homeless Services Network Council (HSNC). The Homeless Services Network Council is the group of area agencies that the Board of County Supervisors tasked with coordinating and promoting homeless services in the Prince William County Area. Many agencies such as the local emergency shelters, transitional and permanent housing programs, and emergency assistance programs are members. The Prince William Area Departments of Social Services (Prince William County, The Cities of Manassas and Manassas Park), the county Housing and Community Development Agency and the Community Services Board all participate in, but are not voting members of the HSNC. Currently the PATH supervisor, in addition to the C of C meeting, attends a variety of Community Action Teams (CAT). She sits on the Point-In-Time Count CAT, the Difficult to Serve CAT, the HMIS steering committee, and is the point person in coordinating the development of the area's strategy on ending chronic homelessness. The PATH supervisor also attends a meeting with the area homeless services providers and the Chairman of the PWC Board of County Supervisors and a Supervisor who has a long history of supporting the needs of the homeless and less fortunate in the county. As a government employee, the PATH supervisor cannot vote on issues that come before the HSNC.

**Cultural Competence:**

The CSB, the umbrella organization for PATH, is composed of 165 women and 31 men for a total of 196 administrative and clinical employees. Of the 196 staff, 40 are Black; 147 are Caucasian; 5 are Hispanic; 2 are Asian/Pacific Islander; 2 are other and there are no American Indians on staff. The PATH staff are 2 Caucasian women however, the Residential Program and the hierarchy responsible for the overall supervision of the program demonstrates a range of gender, racial and cultural backgrounds. At this time it is estimated that Prince William County has 65% Caucasian residents, 19% African American residents, 10% Hispanic and 4% are Asian residents. The PATH staff are training in ethics and cultural competency by the CSB, in addition these staff are both Licensed Professional Counselors and consequently are bound by those education, experience and professional requirements. The CSB trainings include an initial half day training in cultural competence, and yearly follow-up programs. In addition both PATH counselors receive bi-monthly clinical supervision, and cultural competency is an ongoing focus. The PATH counselors have a long

history in treating people with Serious Mental Illness with a variety of backgrounds, race, age and disability. The Supervisor has been working with homeless services and/or people with serious mental illness for over 20 years and the PATH therapist has been in the field for 8 years. The PATH counselor has the ability to speak some Spanish. PATH, through a CSB contract with LLE, has access to face-to-face and telephonic translation, for consumers who are hearing impaired, or whose primary language is something other than English.

**Consumer/Family Involvement:**

The CSB provides training on Customer Service to all staff. The organization completes annual surveys soliciting feedback from consumers, families of consumers, and other services providers. The CSB obtains current information on the needs of the local homeless people from the following sources: the Homeless Services Network Council, the Community Action Teams (especially the C of C, which has several consumers involved in the process and development), and in coordination with other services providers and consumers. This information is used for planning, assessment, and implementation. This is an ongoing process including re-assessment and continued development of services. The PATH program also uses customer feedback on services. This is primarily from the other agencies that serve the homeless; also included is consumer feedback and feedback from families (when the family is available).

**Prince William County Budget Form** FFY04 / SFY05

| Category | | | PATH Funded Amount | Non-Federal Direct Match | Source of Match Cash or In-Kind *( delete one)* |
|---|---|---|---|---|---|
| **Staff Title** | **Annual Salary** | **FTE** | | | |
| *e.g.: Outreach Staff* | [redacted] | *0.5* | [redacted] | [redacted] | *Cash* |
| (1)Outreach staff | [redacted] | 0.59 | [redacted] | | Cash |
| (2)Outreach back-up | $[redacted]/hr for 12.5 hrs per week for 10 weeks | temp | [redacted] | | Cash |
| (3)Supervisor | $[redacted] | .16 | | [redacted] | Cash |
| | | | | | Cash / In-Kind |
| | | | | | Cash / In-Kind |
| **TOTAL PERSONNEL** | | | [redacted] | [redacted] | Cash / In-Kind |
| **TOTAL FRINGE BENEFITS** | | | [redacted] | [redacted] | Cash / In-Kind |
| **Travel** *e.g.: Outreach, or travel to training, or travel to state meetings* | | | | | |
| (4)Travel | | | $ | $ [redacted] | Cash |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Equipment** *List individually any non-expendable, tangible personal property having a useful life of more than one year.* | | | | | |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Supplies** *e.g.: Program Supplies or Computer Software* | | | | | |
| (5)HSN HMIS license fees for 2 users | | | [redacted] | [redacted] | Cash |
| (6)Cell Phone charges | | | [redacted] | [redacted] | Cash |
| | | | $ | $ | Cash / In-Kind |
| **Contractual** *If more contracted services, attach an additional sheet with description.* | | | | | |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Other** *Describe any other proposed expenditures* | | | | | |
| (7) client concrete services | | | [redacted] | [redacted] | Cash |
| (8) Office Rent | | | | [redacted] | |
| (9) Training/Conferences | | | [redacted] | [redacted] | Cash |
| | | | **PATH** | **Match** | |
| **Total PATH Budget** | | | $38,178.00 | $17,529.00 | |

1. **Provider Organization**: **Rappahannock Area Community Services Board** (RACSB) serves Planning District 16 constituting Spotsylvania, Stafford, Caroline and King George Counties and the City of Fredericksburg. RACSB is the public MHMRSAS for the district.

**2. PATH Funds**: RACSB anticipates receiving $21,914 in PATH funds. RACSB will provide $7,305 in match, meeting the 25% match requirement. The matching funds will be available July 1, 2004. The total program will cost $29,217. The local match from RACSB will be available at the beginning of the grant period. (See enclosed budget form)

3. **Services Plan**: Coordinated and comprehensive services to eligible PATH clients will be provided as follows:

   a. projected number of clients who will receive PATH funded services RACSB projects 40 clients to be enrolled in the PATH program in FY 2005 (i.e., 7/1/2004 – 6/30/2005). Enrolled PATH clients served by Federal PATH funds will be 26. The total number of persons receiving Federal PATH supported services during the year will be 185. More than 80% are projected to be "literally homeless," i.e. outdoors or in emergency shelter.

   b. list and describe how specific services are to be provided Specific services to be provided by this part-time PATH position include outreach services; screening and diagnostic treatment services; and referrals for primary health services, job training, educational services and relevant housing services subject to the restrictions cited in the "Restrictions on the Use of Funds."
   RACSB plans to use PATH funding to better coordinate and increase mental health services for individuals in shelters or who are otherwise homeless. Our target population are individuals who have serious mental illnesses or who have mental illness and co-occurring substance abuse disorders within the homeless and imminently at-risk population. The PATH Case Manager will outreach and assess individuals. They will then work with staff at the various shelters and agencies to link individuals to needed services. The PATH Case Manager adds an element of trust, rapport, and communication benefiting our target population and increasing effective delivery of services from multiple agencies.

   c. Several existing programs provide key services to PATH eligible clients, but there remain gaps in the current service system. Thurman-Brisben Homeless Shelter serves homeless individuals and families. Hope House is a transition shelter for women and children who are homeless and need assistance in childcare, job training and establishing themselves in more permanent housing. Rappahannock Council on Domestic Violence sponsors a shelter for women and children who need shelter from abusive relationships. All three of these shelters serve individuals who may also have a diagnosis of serious mental illness. Several area churches and food relief clearinghouses assist persons who are homeless, including PATH-eligible clients. The PATH Case Manager has developed a strong support network with the faith-based community. The Case Manager regularly refers PATH consumers to Fredericksburg Baptist Church, Living Waters Tabernacle, Trinity Episcopal, Horizons Community Church,

Redeemer Lutheran Church and Grace Church..

These ministries provide food, clothing, shoes, sleeping bags, quilts and various sundry items to PATH consumers. Trinity Episcopal provides a breakfast and place for PATH consumers to shower several days a week. Fredericksburg Baptist Church provides a site for a meal once a week. Both of these locations offer opportunities for the PATH Case Manager to meet consumers for assessment of need and sharing of resources. In addition, Store House Ministries have volunteers who deliver food to several locations in Fredericksburg as well as Spotsylvania County. The PATH Case Manager is able to go with these volunteers and meet consumers in nontraditional locations for the purpose of assessing need, building rapport and providing information on resources.
Individuals in need of security deposits and other rental assistance will be referred to the Central Virginia Housing Coalition. Section 8 is included in services provided by the Housing Coalition. Other resources to be used for rental assistance are the SERVE program and CAP.

Individuals enrolled in RACSB services will be offered assistance in budgeting and bill paying. RACSB will also become a person's payee if appropriate. RACSB Case Management and Residential Services may also be able to assist in the provision of Section 8 Housing vouchers

d. Gaps in service delivery include:
    - Lack of trust with necessary and knowledgeable staff
    - Lack of transportation
    - Insufficient funds and coordination to access medications
    - Difficulty in securing affordable housing
    - Difficulty in securing, managing, and budgeting resources

e. The special needs of homeless clients with co-occurring serious mental illness and substance abuse disorders will be met much better due to the RACSB PATH supported staff person. PATH staff will provide initial screening and assessment to determine general needs and mental health issues that need to be addressed. The individual will then be referred to RACSB for needed services. As appropriate, PATH staff will advocate for referrals and they will aid program staff to establish better rapport. PATH staff will aggressively provide individualized support and service to improve the likelihood of follow-through by the consumer.

The PATH Case Manager will assist the consumer in securing transportation resources by introducing the individual to the Fredericksburg Public Transportation System and training the individual, if needed, in the use of the system. Medicaid funded transportation services will be pursued where appropriate once Medicaid has been applied for and secured. When possible, the PATH case manager will transport the individual until the individual is established in the community in permanent housing and transportation alternatives have been arranged.

PATH participants are also given information about AA and NA meetings. The PATH Case Manager encourages participation in these meetings by providing support and assistance to find transportation and contacts.

Individuals in need of assistance in paying for medication will be linked to local resources such as SERVE, CAP and MAP. Resources through medical insurances such as Medicaid will be used. When appropriate the individual will also be referred to RACSB for an array of mental health services, including medications.

f. Suitable housing services will be made available to PATH eligible individuals. PATH eligible individuals will be provided information regarding the availability of Section 8 vouchers, Section 8 apartments, and methods to link with the Central Virginia Housing Coalition and Hope House when appropriate. The PATH staff will provide assistance with information gathering, applications, and transportation when needed. Names of sponsors, locations of housing services, and assistance in linking to programs will be provided by PATH staff.

**4. Coordination with HUD Continuum of Care**: The PATH program is rooted in working closely with other agencies concerned with serving the homeless, near homeless and underserved individuals and families of our community. The PATH program Outreach Worker is an active member of the Community Housing Partners (CHP) consortium, which is comprised of more than 25 agencies serving Planning District 16 (PD 16) with the express goal of abating homelessness, and conditions that may lead to homelessness. The PATH program Outreach Worker attends the monthly CHP meetings and collaborates with the public, private, and non-profit businesses and organizations to identify gaps in services which may lead to homelessness in addition to coordinating services that enable homeless families to access shelters and other supportive services. In addition, the PATH Outreach Worker actively participates with interfaith groups and churches within the planning district by providing mental health and other referral services for individuals/families identified as resistant to access services. Recently, the PATH program assisted CHP in conducting a Statewide Point-in-Time (PIT) count of the homeless of planning District 16. Subsequently, PATH is currently assisting the CHP in developing seasonal Thermal Shelters, a need identified by the PIT count. PATH will continue to assist CHP in organizing the Continuum of Care Plan for PD 16 as well as identifying and addressing gaps in services.

**5.Cultural Competence**: RACSB PATH funded staff providing services to the target population will be sensitive to age, gender and racial/ethnic differences. As part of a CARF accredited case management system, all staff are required to have training at least annually in the issues of cultural diversity. Staff are also responsible for demonstrating this competency in service planning and service delivery. In addition, PATH staff will be given the opportunity to attend training provided by or recommended by the state PATH program

**Organizational Profile for Race/Ethnicity**

| Race | PATH Consumer | RACSB Employee | PATH Employee | Community Profile |
|---|---|---|---|---|
| American Indian or Alaska Native | 1 | 2 (<1%) | 0 | 0% |
| Asian | 0 | 6 (2%) | 0 | 1% |
| Black or African American | 3 | 80 (23%) | 0 | 16% |
| Hispanic or Latino | 2 | 4 (1%) | 0 | 3% of total |
| Native Hawaiian or Pacific Islander | 0 | 0 | 0 | 0% |
| White | 20 | 256 (74%) | 1 | 81% |
| Other | 0 | 0 | 0 | 3% |

6. **Consumer/Family Involvement:** Homeless consumers and their family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH funded services. As a CARF accredited organization, RACSB has a documented history of positive, programmatic involvement of recipients of mental health services and their families. During the course of this year, a concerted effort will be directed to involve PATH participants in the completion of satisfaction survey applicable to PATH services they receive. Additionally, referral source surveys will be sent to area programs who may work with PATH eligible consumers and RACSB.

   Our mission as well as consumer rights process reflect the value of involving consumers and family members in order to improve outcomes. Recipients of PATH services are fully informed of the benefits and risks of services and make a voluntary decision, without threats or coercion, to receive or reject services at any time. Consumers and family members are fully informed of their rights regarding information disclosure, choice of providers and plans, access to emergency services, participation in treatment decisions, respect in non-discrimination, confidentiality of health care information, complaints and appeals, and consumer responsibilities.

**Budget Form** RACSB FFY04 / SFY05

| Category | | | PATH Funded Amount | Non-Federal Direct Match | Source of Match Cash or In-Kind *( delete one)* |
|---|---|---|---|---|---|
| **Staff Title** | **Annual Salary** | **FTE** | | | |
| *e.g.: Outreach Staff* | [redacted] | *0.5* | [redacted] | [redacted] | *Cash* |
| Case Manager | [redacted] | 0.5 | [redacted] | | Cash / In-Kind |
| Coordinator | [redacted] | 0.05 | | [redacted] | In-Kind |
| | | | | | Cash / In-Kind |
| | | | | | Cash / In-Kind |
| | | | | | Cash / In-Kind |
| **TOTAL PERSONNEL** | | | [redacted] | [redacted] | |
| **TOTAL FRINGE BENEFITS** | | | [redacted] | [redacted] | |
| **Travel** *e.g.: Outreach, or travel to training, or travel to state meetings* | | | | | |
| Outreach Mileage | | | $ | [redacted] | In-Kind |
| Travel to training / workshops | | | $ | [redacted] | In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Equipment** *List individually any non-expendable, tangible personal property having a useful life of more than one year.* | | | | | |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Supplies** *e.g.: Program Supplies or Computer Software* | | | | | |
| Program supplies | | | $ | [redacted] | In-Kind |
| | | | $ | [redacted] | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Contractual** *If more contracted services, attach an additional sheet with description.* | | | | | |
| | | | $ | $ | Cash / In-Kind |
| | | | $ | $ | Cash / In-Kind |
| **Other** *Describe any other proposed expenditures* | | | | | |
| **Occupancy Costs** | | | $ | $[redacted] | In-Kind |
| | | | $ | $ | Cash / In-Kind |
| | | | **PATH** | **Match** | |
| **Total PATH Budget** | | | $21914 | $7306 | $29220 |

**PATH APPLICATION FOR**
**FFY 2004 (9/1/04 – 8/31/05) STATE FY04-05 (7/1/04-6/30/05)**

**1. Provider Organization:**
**Region Ten Community Services Board**
800 Preston Avenue, Charlottesville, Virginia 22903-4420

Region Ten CSB is the public provider of services to persons experiencing mental illness, mental retardation, and substance abuse services. As such the agency implements an array of MH and SA clinical and psychiatric treatments and comprehensive community support services, including outreach, hospital liaison, emergency, case management, psychosocial rehabilitation, supported and independent housing services.

Service Area: Thomas Jefferson Planning District:
***(Charlottesville, Albemarle, Louisa, Greene, Nelson, Fluvanna counties)***

**2. PATH Funds: $23,525** in Federal PATH funds

Total PATH program funds equal $32,725, including $9200 in agency Matching funds comprised of other State MH program funds and available beginning July 1, 2004.

**PATH**: The agency PATH services are provided by two staff. The PATH Coordinator/Case Manager devotes half-time to this project. This totals $[redacted] and $[redacted] in salary and fringe respectively. The position provides direct outreach and engagement and referrals services to PATH recipients and coordinates the overall work of Outreach and collaborations with primary service providers for this population in the community. Together with the part-time outreach staff below, the overall PATH effort is .75 FTE. Un-represented in this description is the deployment (as available) of a UVA psychology student intern to the overall PATH effort as well. The agency expends the balance of PATH funds in Outreach travel to service sites, on occasional training expenses; or on program supplies and a modest amount on recipient housing payments, security deposits.
PATH Match: The agency deploys a half-time PATH Outreach staff with matching funds who devotes half of his service effort to PATH activities. ($[redacted]) In addition the agency expends matching funds in cash for Outreach travel ($[redacted]; Supplies ($[redacted]), and Offices and communications ($[redacted]).

**3. Service Plan:**

| a. FFY 2004 Projected number of clients to be served **= 78 100% Literally Homeless** |
|---|

This number reflects the total anticipated PATH clients to be served using Federal PATH funding.

| b. Specific Eligible Service Are To Be Provided: |
|---|

Two staff comprise the agency's PATH efforts with outreach to the streets, the homeless shelters, the consumer Drop-In Center, and the local psychiatric hospitals. One serves as the project supervisor and is a full-time specialized outreach case manager. Half of his effort is in PATH and the other is with a special partnership project with a consumer Drop-In Center,

PACSS (Partnership for Assertive Community Street Services). This combination has enhanced agency engagement potential with the homeless mentally ill population. These positions provide the following services. Most services are provided with partial involvement of PATH staff and funds; the agency is heavily invested through other programs of service to this chronically homeless population. (See Key service programs below):

**Outreach:** Outreach staff attend a regular, weekly Case Disposition meeting at the local Salvation Army shelter where potentially eligible PATH service recipients are identified, reviewed and plans initiated for engagement. Agency ACCESS staff directly refer newly presenting homeless mentally ill persons to the PATH service team, as well.

**Screening and Diagnosis treatment services:** PATH staff arrange meetings with potential PATH recipients in the field, evaluate for eligibility and need of PATH services, enroll as needed, and proceed with direct assistance and referral for needed treatments and supports.

**Habilitation and Rehabilitation services:** PATH staff provide initial direct assistance to PATH service recipients to implement a wide variety of goals for movement away from homelessness. Strong initial efforts are made to engage the person's interest in mental health and substance abuse treatment services.

**Community Mental Health services:** PATH staff make referrals to Region Ten CSB ACCESS and directly assist consumers to complete this intake. The same staff frequently collaborate with a local PATH partner (On Our Own of Charlottesville) on the admission of consumers to PACSS a collaborative outreach and engagement service for disengaged seriously mentally ill individuals.

**Alcohol and Drug Treatment services:** PATH staff assist by referral to Substance Addictions treatment services at Region Ten CSB. As needed, referral to the MOHR Center public inebriate shelter and transitional residential substance addiction service is made.

**Case management services:** All eligible PATH consumers receive case management necessary to engage and hold them in service until they are enrolled and stabilized in other formal mainstream agency or community resources.

**Referrals for Primary Health services, et al.** By referral.

**Housing services: Planning; Technical Assistance in applying; Improving Coordination of Housing; Security deposits, One time rental assistance or Other amenities:** PATH staff regularly attend Region Ten's weekly Housing Resource Meeting to represent the needs of homeless persons. The meeting makes all decisions regarding the award of Section 8 certificates; keeps all staff informed of other Section 8 resources available through regional Housing Authorities; and monitors and awards Shelter Plus Care certificates and Supported Housing Program vacancies.

c. Community Organizations Providing key services to PATH-eligible persons:

| Organization | Primary Health | Mental Health | Substance Abuse | Housing | Food/Clothing | Benefits |
|---|---|---|---|---|---|---|
| Salvation Army shelter | referral | | | Emergency shelter | Thrift Store | Medical Assistance Program – benefits applications |

| | | | | | | |
|---|---|---|---|---|---|---|
| On Our Own Drop-In Center | Referral and transportation | Peer-supports | | Outreach; transitional housing beds | Clothing closet Day time food | Benefit application transportation |
| Region Ten CSB | MH case management/assessment and referral to primary medical care | MH case management/ provision of assertive community treatment and community support services; Employment Services | Mohr Center public inebriate detox and SA residential treatment | Supportive Permanent Housing Program (dually-diagnosed homeless); Shelter Plus Care Program; Section 8 subsidy program | Blue Ridge Clubhouse thrift Shop | Benefits applications |
| Private Adult Homes | | | | Boarding rooms | | |
| UVA Hospital | Emergency Room services Medical Indigent Care Program | | | | | |
| Free Clinic | Reduced fee medical care | | | | | |
| Local Churches | | | | | Soup Kitchens 5 days per week | Cash assistance |
| TJ Area Food Bank | | | | | Food supplies | |

**The Salvation Army Family Service Center** provides a number of programs assisting indigent, homeless individuals to become self-sufficient. Persons with serious mental illness are able to participate in these services. This Shelter coordinates intensively with Region Ten CSB PATH staff and ***on-our-own, Charlottesville Drop-In Center*** for engagement and follow-up assistance and mental health and dual-diagnosis treatments.

**The Region Ten Community Services Board,** in addition to its PATH-funded activities, as a public provider of mental health and substance addictions services, operates a number of projects which target homeless, seriously mentally ill persons: a Continuum of Care Supportive Housing Program, the **Dual-Recovery Center** for homeless, dually-diagnosed SMI persons; a PACT-model service (PACSS) jointly operated with ***on our own—charlottesville*** **Drop-In Center** providing intensive engagement and treatment services to homeless and at-risk individuals with SMI; and Shelter Plus Care. In addition the **Mohr Center** provides a public inebriate shelter resource and substance abuse residential treatment for homeless, alcohol abusing men, including dually diagnosed individuals.

Through its collaborative work with the Continuum of Care committee of the Homeless Coalition, the PATH staff also identified and used a few resources of participant agencies in the area's Non-Profit Housing Developers forum. Clearly, the area's Church-sponsored **soup kitchen services** are an important resource.

d. Gaps Experienced in Specific Service System

The Region Ten PATH strategy to date has been to provide engagement up front with linkages to immediate help as this can be accessed. The use of the agency's PACSS project case manager (Program for Assertive Community Street Services) as a resource for the PATH-identified consumer continues to be a helpful strategy. PATH staff identify the following as continuing major obstacles and challenges to addressing the chronically homeless, SMI persons in our region:

Limited, easily-accessed, medical care services: Most consumers use the Emergency Room at UVA hospital as a primary care provider. Indigent care is limited and access to UVA Primary Indigent Care Program is typically a protracted process not easily tolerated or negotiated by PATH eligible consumers.
Dentistry Services are limited: Preventive dentistry and Orthodontics are major unmet need areas.
Housing Needs: Affordable housing and subsidy resources remain a major gap in the region's ability to respond to resource needs of homeless persons. Rental costs remain high. From homeless surveys conducted by the Continuum of Care committee, it appears that shelter bed capacity, though adequate for the region generally, is limited for persons who are chronically homeless due to alcohol and drug addictions. Limited supportive housing--- both transitional and permanent--- causes gaps in care for those homeless persons experiencing serious mental illnesses or addictions. Mainstream resources for intensive engagement of homeless persons in substance abuse or mental health services remain overburdened.

In addition, the region has a limited supply of Boarding Home beds. There are extremely few single-room occupancy resources as a part of a continuum to move PATH-eligible consumers towards permanent housing.

e. Services available to clients with co-occurring mental illnesses and substance addiction disorders:

- PATH staff assess for emergent needs for public inebriate shelter or social detox and assist the consumer's movement to Mohr Center residential services or New Hope Social Detox services.
- PATH staff assess and refer dually diagnosed homeless clients to appropriate services at Region Ten CSB. Staff may continue long-term agency services to the same clients as enrolled to PACSS, a specialized engagement program for reluctant, disengaged needy homeless consumers.
- The PATH staff provide direct assistance to PATH clients to make and keep Intake appointments with agency ACCESS staff.
- Staff link the client to mainstream MICA services through Region Ten CSB;
- Staff support attendance; consult with facilitators, and provide follow-up to the PATH client to reinforce participation with available care: case management, psychiatric evaluation, medication, Dual-Recovery Center services, Mohr Center services; specialized MICA group treatments, etc.
- Staff assist in identifying appropriate AA meetings as well.

f. Strategies for making suitable housing available to PATH clients:

- PATH staff attend a weekly Region Ten Housing Resource Committee to reflect need and advocate for rental subsidies and/or residential placements in programs.
- PATH staff confer regularly with the Region Ten Section 8 Housing Agent, a repository for openings in boarding homes, adult homes, shared housing possibilities, and other reduced-rent units in the area.
- PATH staff are in continuous planning with the Salvation Army shelter for persons eligible for PATH services.
- PATH staff work with the consumer Drop-In Center and the MOHR Center to make effective use of public inebriate and transitional beds in these facilities, assuring that PATH clients gain access.
- The PATH/PACSS case manager accesses agency loan funds to assist PATH clients to access temporary housing as they stabilize, develop resources, and move towards permanent housing.
- PATH staff identify potential PATH clients for the agency's Shelter Plus Care funds.

**4. Coordination with HUD Continuum of Care Strategic Planning**:

The agency's PATH services are fully integrated with the region's planning processes for homeless persons through the Thomas Jefferson Area Coalition for the Homeless. Now fifty organizations strong, this group conducts all the strategic planning activities involved in the creation of the region's Continuum of Care Plan for the homeless. Region Ten CSB's Director of Rehabilitation Services co-chairs this Coalition and serves as supervisor of the PATH efforts as well. The agency's PATH efforts are well represented in the strategic planning processes which result in good homeless needs surveys and the generation and prioritization of applications for McKinney Vento Act funds.

PATH providers regularly participate in community assessment and planning relevant to PATH eligible individuals. For instance, PATH staff and PATH recipients were recently represented in a community-wide forum, "Homelessness in a World Class Community"

Major homeless service providers in the area participate in the Coalition and are very aware of a visible and active PATH staff effort. PATH staff and the Salvation Army Service Center work in tandem to identify and encourage PATH-eligible clients to engage with the PATH staff. PATH efforts coordinate as well with other agency service programs funded through successful CoC project applications (Supportive Housing Program and a Shelter Plus Care project).

**5. Cultural Competence:**

Agency Staff Race/Ethnicity: 75.1% white; 22.2% African American; 1.1% Hispanic; .6% Asian American; .3% Native American; .7 % Other.
PATH Staff Race/Ethnicity: 50% white; 50% African American
Community: 81% white; 15% African American; 2% Hispanic, 2% Asian American; 2% Other

The agency generally and the PATH program in particular have adopted a number of practices that assure services are provided in a manner that is sensitive to age, gender, and racial/ethnic differences of the homeless population.

- The PATH program at least annually evaluates its target population statistics in the domains above with analysis and review of needed changes/goals in a variety of areas in order to remain responsive.
- The agency maintains a roster of staff with multi-linguistic abilities and assures that the PATH staff may access these resources for facilitating communications with PATH-eligible clients.
- The PATH program staffing is comprised of staff with significant experience with the needs of the target population. Staff, for instance, are in long-term recovery from substance addictions. Staff members have significant mental health service experience doing outreach and engagement of the chronically homeless mentally ill persons in the area.
- The PATH project staff conduct informal meetings with PATH service recipients during the course of the year to ascertain feedback about a variety of project efforts.
- PATH staff participate in agency sponsored cultural diversity training events at least yearly.

**6. Consumer/Family Involvement:**

The agency and program have adopted a number of ways to assure the maximum accessibility and opportunity for homeless consumers and their families to be involved in the planning, implementation, and evaluation of PATH-funded services.

- PATH activities are reviewed weekly in a collaborative program meeting with members of the consumer Drop-In Center, who are mental health consumers themselves as well as, in many cases, formerly homeless persons themselves. These participants plan individual and general program supports and services for PATH service recipients.
- PATH staff confer weekly with the Salvation Army and homeless individuals in this location about the program's practices.

- The agency has an active Consumer and Family Advocate office directly accessible to consumers. Though ostensibly focused in immediate areas of consumer complaint, the office identifies opportunities for the agency and its programs, including the PATH service to be more responsive to client needs, concerns and preferences.
- The agency has a comprehensive protocol for initial and ongoing notification of consumer rights and protection of consumer information.
- The agency's Board of Directors has mandated positions for at least one consumer and multiple family members. Advisory committees to the Board are balanced in their memberships of working professionals and consumer and family members. Members of the agency's Board of Directors meet with regularly with homeless participants in several of the agency's service programs to this population.
- The agency has a demonstrated commitment to the recruitment and hiring of consumer staff.
- The PATH staff present at least annually to the Blue Ridge Family Alliance for the Mentally Ill.
- The PATH staff work daily and collaboratively with the regions consumer-run Drop-In Center, a co-partner with the agency in a number of service programs, including the mutual work in PATH activities.

**Budget Form: Region Ten Community Service Board PATH FFY 2004**

| Category | | | PATH Funded Amount | Non-Federal Direct Match | Source of Match Cash or In-Kind *( delete one*) |
|---|---|---|---|---|---|
| **Staff Title** | **Annual Salary** | **FTE** | | | |
| *e.g.: Outreach Staff* | [redacted] | *0.5* | [redacted] | [redacted] | *Cash* |
| PATH Outreach staff | [redacted] | 0.5 | [redacted] | | **Cash** |
| PATH Outreach staff | [redacted] | 0.125 | | [redacted] | **Cash** |
| | | | | | |
| | | | | | |
| | | | | | |
| **TOTAL PERSONNEL** | | | [redacted] | [redacted] | **Cash** |
| **TOTAL FRINGE BENEFITS** | | | [redacted] | [redacted] | |
| **Travel** *e.g.: Outreach or Travel to State Meetings* | | | | | |
| Outreach | | | [redacted] | [redacted] | **Cash** |
| Travel to training, workshops | | | [redacted] | [redacted] | **Cash** |
| **Equipment*** *List individually any non-expendable, tangible personal property having a useful life of more than one year.* | | | | | |
| | | | $ | $ | |
| | | | $ | $ | |
| | | | $ | $ | |
| **Supplies** *e.g.: Program Supplies or Computer Software* | | | | | |
| Program supplies | | | [redacted] | [redacted] | **cash** |
| | | | $ | $ | |
| | | | $ | $ | |
| **Contractual*** *If more than one contracted service, attach an additional sheet with description.* | | | | | |
| | | | $ | $ | Cash / In-Kind |
| **Other** *Describe any other proposed expenditures* | | | | | |
| Housing (rental assistance) | | | [redacted] | | **Cash** |
| Office/utils/phone | | | | [redacted] | **In-Kind** |
| | | | **PATH** | **Match** | |
| **Total PATH Budget** | | | **$23,525** | **$9,200** | |

Note: The PATH budget period runs from 9/1/03 through 8/31/04, even though the reporting period runs from 7/1/03 through 6/30/04.

1. **Provider Organization:**

The **Richmond Behavioral Health Authority (RBHA)** is the public agency providing mental health, mental retardation, substance abuse, prevention, and children's services to residents of the City of Richmond, Virginia. The RBHA is a quasi-governmental agency created by the Virginia General Assembly through resolution 96-R106-100.

2. **PATH Funds:**

Per the FY2005 PATH allocation table, the RBHA has been allotted a total award, including incentive, of $99,596. The attached Budget Form details the planned program expenditures, how the allocated PATH funds will be distributed, and the type and source of the match. All match funds, totaling $91,700, will be made available on July 1, 2004.

[redacted] percent of the PATH funds have been designated for 1.5 FTE staff, who will provide primarily outreach and case management services to qualified recipients. Some staff time may be spent educating the public, area churches, businesses, and civic groups about the homeless population and services available. The Program Supervisor spends approximately 20% of her time monitoring and directly supervising staff in this program. The Adult Mental Health Director spends 3% of her time providing administrative oversight. The budget indicates that the total agency match for personnel is $[redacted]. Since staff spend most of their time in the field, the full-time use of at least 1 agency vehicle is required with occasional use of an additional vehicle. Travel expenses total $[redacted] of which $[redacted] will be paid for through the use of PATH funds with the remaining $4,000 as agency match. RBHA will provide an in-kind match of $[redacted] to cover the costs of cell phones, office phones, and office computers. This will include the cost to the agency of registering homeless services staff to use the HelpNet software program. Under the Supplies category, $[redacted] of PATH funds will enable staff to help uninsured recipients purchase medications, and an additional $[redacted] match will be provided by the agency to cover the costs of all other supplies utilized by staff. Psychiatric services will be provided to recipients at a cost of $[redacted] per hour with an average utilization of 4 hours per week. The total PATH expense equals $[redacted]. Finally, [redacted]% of PATH funds ($[redacted]) will be reserved to assist recipients with rental assistance, especially one-time security deposit assistance. RBHA estimates that [redacted]% of the budget for its 24-hour, 7-day onsite Crisis and Intake Services Unit, approximately $[redacted], will be made available as a match for the PATH program. Because the RBHA has PATH staff who are able to provide services to homeless persons with mental illness, homeless individuals presenting at Crisis/Intake on their own, through community referral, or through the police department are prioritized over other persons who are already on the waiting list for RBHA services. An additional $[redacted] in in-kind match will be provided through the use of its annual staff training expenses, and administrative overhead costs.

3. **Services Plan:**

   a. RBHA expects to serve 295 clients through the PATH program during FY2005. Of this number, approximately 35% are projected to be "literally homeless."

b. Outreach services: The PATH workers will perform outreach services at local lunch sites, churches, emergency shelters, area parks, and near the Virginia Commonwealth University Campus.
Screening and diagnostic assessment services: The PATH workers will provide a mental status exam (MSE) for all outreached individuals and then utilize a simple diagnostic tool to determine what services are needed.
Community mental health services: The PATH workers will refer enrolled PATH clients to the RBHA, the Virginia Commonwealth University Medical Center, and local private therapists/psychiatrists, for mainstream mental health services.
Alcohol or drug treatment services: The PATH workers will refer clients to the RBHA's substance abuse orientation and/or crisis stabilization when the need is determined.
Case management services: The PATH workers will provide brief (6- month) follow-along to clients placed in transitional and permanent housing and assist them with linkage to other mainstream services, such as social services, Social Security Administration, and the Department of Motor Vehicles.
Primary health services: The PATH workers will provide referrals to the Fan Free Clinic, Crossover health ministries, REACH, and the Daily Planet.
Housing services: The PATH workers will assist clients in applying for private sector housing (i.e. rooming homes, apartment complexes, and subsidized housing). The worker will also place clients on the Shelter Plus Care waiting list and monitor the referrals.

c. RBHA's PATH worker has formed collaborative working relationships with staff at the different agencies listed above. For example, the clergy and staff at the lunch sites often assist the worker in identifying individuals who appear to need mental health services. The worker is able to rely on a list of local therapists and psychiatrists who are willing to provide services on a sliding scale fee. Through RBHA, the worker can make direct referrals to both the mental health and substance abuse departments. While the following is not a comprehensive list of community resources, it illustrates the variety and number of service agencies available:

Richmond Behavioral Health Authority
Richmond Redevelopment and Housing Authority
Rubicon
Crossover Health Ministries
Central Virginia Independent Living Center
Adult Learning Center
YWCA
Area church meal ministries
Housing Opportunities Made Equal

d. There are a number of gaps in the homeless services system which negatively impact a PATH client's ability to obtain and maintain stability. Some of the gaps include: lacking or not being eligible for Medicaid; a shortage of commercial payees; housing that is priced out of the range of most recipients; an overburdened public health, public mental health, and public substance abuse services system; recipients with a lack employable, marketable skills or with limited employment opportunities due to criminal histories; and a shrinking number of available beds at assisted living facilities for those who need this level of care.

e. Currently the RBHA is at the forefront of utilizing state reinvestment money to revitalize group-oriented treatment through the Mental Illness and Chemical & Alcohol Abuse (MICAA) model. The PATH worker is able to make referrals to MICAA groups, which are readily and immediately available to clients, at the same time that referrals are made to the triage and assessment department.

f. The RBHA participates in the Greater Richmond Continuum of Care planning process and is a sub-grantee of permanent housing funds. The community's plan for assisting persons through the crisis of homelessness is to streamline services and housing through a centralized intake process. Homeless persons can then access the range of available shelter and housing services, if eligible, through this process. PATH workers meet with recipients to evaluate individual resources and discuss available and appropriate housing options, which may be the private housing market (with landlords accepting lower income/poor credit tenants), rooming houses, adult care facilities, subsidized housing (Shelter Plus Care, SRO, Section 8), or public housing. PATH staff assist clients with identifying choices, making phone calls, completing housing applications, and locating affordable furnishings.

**4. <u>Coordination with HUD Continuum of Care:</u>**

Staff from the Residential Support Services Unit of the RBHA participate in several HUD Continuum of Care committees. A PATH worker attends the monthly Homeward Agency Providers' meeting, and the Adult Mental Health Director coordinates the Executive Directors' monthly meeting. Also, five homeless and support services staff will be trained to utilize HelpNet, as a means to provide a more coordinated level of services.

**5. <u>Cultural Competence:</u>**

The RBHA staff racial/ethnicity profile is as follows: 218 (67%)African-American (not Hispanic); 2 (<1%)Hispanic; 107(33%) white (not Hispanic). The community profile is as follows: 58% African American; 39% White; 1% Asian; 3% other; 3% of total reporting Hispanic ethnicity. Both PATH staff are African-American, one male and one female, and have extensive experience working with challenging populations, including persons who are homeless, seriously mentally ill, chronic substance abusers, and who have been difficult to engage in traditional support services. The staff are active and well-known in the homeless services community and make an effort to participate in local planning efforts.

The RBHA has made a commitment to cultural competence within the agency and the community at large and is proud to be the newest affiliate of the National Coalition Building Institute (NCBI). The RBHA is in the process of implementing a comprehensive, agency-wide cultural competence/diversity training program based on the NCBI model. As well, within the Residential Support Services Unit, annual retreats are held, so that staff can receive informal training on self-awareness, diversity, and teamwork.

**6. Consumer/Family Involvement:**

The RBHA involves families and consumers in a number of meaningful ways. RBHA has been a leader in forming family support groups for consumers and their families. Local churches, community centers, and schools have collaborated with RBHA to allow the groups to be held at their facilities as a means to better reach consumers, their families, and the community. RBHA involves consumers and family members on its Board of Directors and employs consumers in supportive and direct service capacities. Annually, consumers complete anonymous evaluation forms coordinated by the RBHA's consumer advocate to provide feedback on the services the agency provides. Finally, RBHA staff complete annual training on human rights and confidentiality/privacy regulations.

Richmond Behavioral Health Authority PATH FFY04/SFY05

| Category | | | PATH Funded Amount | Non-Federal Direct Match | Source of Match Cash or In-Kind ( *delete one*) |
|---|---|---|---|---|---|
| **Staff Title** | **Annual Salary** | **FTE** | | | |
| *e.g.: Outreach Staff* | [redacted] | *0.5* | [redacted] | [redacted] | *Cash* |
| Outreach Staff | [redacted] | 1.0 | [redacted] | [redacted] | |
| Outreach Staff | [redacted] | .5 | [redacted] | [redacted] | |
| Program Supervisor | [redacted] | .2 | [redacted] | [redacted] | In-Kind |
| Adult MH Director | [redacted] | .03 | [redacted] | [redacted] | In-Kind |
| | | | | | |
| | | | | | |
| **TOTAL PERSONNEL** | | | [redacted] | [redacted] | In-Kind |
| **TOTAL FRINGE BENEFITS** | | | [redacted] | [redacted] | In-Kind |
| **Travel** *e.g.: Outreach, or travel to training, or travel to state meetings* | | | | | |
| Use of agency vehicle | | | [redacted] | [redacted] | In-Kind |
| | | | $ | $ | |
| | | | $ | $ | |
| **Equipment** *List individually any non-expendable, tangible personal property having a useful life of more than one year.* | | | | | |
| Cell phones/office phones/office computers | | | [redacted] | [redacted] | In-Kind |
| | | | $ | $ | |
| | | | $ | $ | |
| **Supplies** *e.g.: Program Supplies or Computer Software* | | | | | |
| Medications | | | [redacted] | [redacted] | |
| Program supplies | | | [redacted] | [redacted] | In-Kind |
| | | | $ | $ | |
| **Contractual** *If more contracted services, attach an additional sheet with description.* | | | | | |
| Psychiatric Services | | | [redacted] | [redacted] | |
| | | | $ | $ | |
| **Other** *Describe any other proposed expenditures* | | | | | |
| Crisis/Intake Unit Services | | | [redacted] | [redacted] | In-Kind |
| Rental Assistance | | | [redacted] | [redacted] | |
| Staff Training (CPI, cultural competency, etc.) | | | [redacted] | [redacted] | In-Kind |
| Administrative Costs | | | [redacted] | [redacted] | In-Kind |
| | | | **PATH** | **Match** | |
| **Total PATH Budget** | | | $99,596 | $91,700 | |

**1. Provider Organization: Virginia Beach Department of Human Services, Mental Health and Substance Abuse Division serving the City of Virginia Beach**. The Mental Health and Substance Abuse Division provides a full range of services from emergency services, prevention, medication management, case management for the seriously mentally ill, day treatment programs for mental illness and substance abuse, supportive residential services, psychosocial day program, to child and youth treatment programs.

**2. PATH Funds:** Please see attached appendix: PATH funding will be used to fund part of the PATH position which is essential for conducting outreach and initial case management, to provide technical assistance in applying for housing, security deposits, one-time rental payments to prevent evection, medications, psychiatric evaluations, bus tokens, food coupons and clothing. Funding will also be used to pay for a cell phone which is necessary due to the outreach efforts of the PATH worker and office supplies.

**3. Services Plan:**

**a.)** Projected number of clients to be served in FY 2005: 85 (90% of these clients are projected to be "literally homeless")

**b.)** Services to be provided:

**Outreach services** are a one on one or group communication process. Information about PATH services is introduced along with resources for housing, food, job searching, shelter, mental health services, substance abuse services, medical health services and financial resources, including entitlements. Outreach services are provided in Virginia Beach where the homeless population tends to congregate and utilize services, including Potters House and Star of the Sea Outreach, who both provide lunch. Judeo Christian Outreach Center is a transitional homeless shelter; Volunteers of America is a day center for the homeless. Virginia Beach Recovery Center provides detoxification services on a referral or walk in basis providing a bed is available. PATH receives referrals from the local hospital emergency rooms regarding treatment for homeless mentally ill. The PATH worker also visits wooded and street sites where the population tends to stay and or sleep.

**Screening** of the needs for mental health services. Each prospective PATH client is interviewed, their need for mental health services assessed and are referred for appropriate services.

**Case management services** include the referral to and purchase of clinical assessments and psychiatric evaluations and the purchase of psychotropic medications. This service also includes linkage to other needed resources, service coordination, crisis intervention, transportation, money management, and advocacy of the behalf of the client.

**Training** is provided to any organization that works or provides services for the homeless population by the PATH worker. This training includes information on homelessness, mental health and substance abuse.

**Referrals** for primary health care are coordinated through Beach Health Clinic and Virginia Beach Health Department.

**Housing services** including planning of housing, technical assistance in applying for housing assistance, security deposits, one-time rental payments to prevent eviction, costs associated with matching eligible homeless individuals with appropriate housing situations.

**c.) Community organizations that provide key services:** Virginia Beach Community Development Corporation and Community Alternatives Management Group provide subsidized transitional housing for the disabled population. The PATH worker assists the client in applying for and submitting applications to the prospective organizations. Virginia Beach Department of Human Services, Mental Health/Substance Abuse Division has subsidized housing for disabled individuals. The PATH worker assists the client in applying for and submitting applications for this housing. Beach Health Clinic is a walk in clinic providing basic medical services and prescription assistance to the uninsured, working poor of Virginia Beach. Virginia Beach Housing and Neighborhood Preservation is a contact point for up to date listings of affordable housing. They are also a resource for a rental security/utility deposit program (Home Funds). Virginia Beach Recovery Center is utilized via referral for detoxification, treatment and AA/NA meetings. Referrals are made to Virginia Beach Department of Human Services, Mental Health and Substance Abuse Division who provides treatment for mental illnesses and substance abuse.

**d.) Gaps**: **Lack of affordable housing** is a serious problem in Virginia Beach with average rentals for a one-bedroom apartment at $790.00. **Lack of Funding for medications:** Medication for medical and mental health is costly and few resources are available to assist with their cost. **Transportation:** Few resources are available to provide the homeless with passes in the quantities needed for treatment services and job searching.

**Dental and vision care** is scarce for clients with little or no income. Dental and vision care is not a service of Beach Health Clinic.

**e.) Services for co-occurring disorders**. The PATH worker refers clients to the Virginia Beach Department of Human Services Substance Abuse Division for outpatient services and day treatment programs. PATH works closely with Virginia Beach Recovery Center via phone referrals, provides a detoxification unit with access to inpatient treatment programs. Virginia Beach Psychiatric Center provides a medical detoxification unit and access to inpatient treatment programs for individuals who are referred.

**f.) Strategies:** The PATH worker will continue to network with apartment owners, motel owners and other possible housing sources to develop additional housing.

**4. Coordination with HUD CoC:** PATH clients are referred to housing programs available through the Virginia Beach Department of Human Services, Mental Health/ Substance Abuse Division, Supportive Residential Services; Department of Housing and Neighborhood Preservation; the Judeo-Christian Outreach Program Transitional Housing Services and the Community Alternative Management Group HUD Homeless and Transitional and Permanent Housing. The PATH worker attends the Virginia Beach Housing Advocacy and Resources Partnership monthly to increase collaboration with

other homeless service providers. The PATH worker attends the monthly Community Action Committee at the Virginia Beach 2nd Precinct.

5. **Cultural Competence:** The PATH program in Virginia Beach has been implemented by the City of Virginia Beach for 10 years and has demonstrated an effective and sensitive outreach to the mentally ill homeless as evidenced by the increase in outreaches and clients effectively referred to mental health and other services. The PATH worker has a reputation among the homeless for discretion, respectfulness and effectiveness. The Virginia Beach Department of Human Services, Mental Health/Substance Abuse Division (who employs the PATH worker) has adopted the city's strategic Cultural Diversity Plan and a CARF approved Cultural Diversity Plan. The PATH worker receives annual cultural diversity training provided by the City of Virginia Beach. Both the Judeo-Christian Outreach Transitional Housing and the Community Alternative Management Group receive federal or city funding that requires they establish a cultural diversity policy. The organizational profile of race/ethnicity for PATH staff is white. The Department's staff reflects the diversity of the homeless population in that 54% are white and 40% African American, 1% is Hispanic, 3% are Asian and 2% are other. The community consists of 73% white, 19% African American, 5% Asian, 5% other, and 4% of total report Hispanic ethnicity. The City of Virginia Beach maintains an Equal Employment Opportunity policy.

6. **Consumer/Family Involvement:** Consumers are represented by the Office of Consumer and Family Affairs and all board meetings are open to the public. All treatment planning involves the input of the consumer who signs off on their treatment plan. Satisfaction surveys are conducted quarterly by the Virginia Beach Department of Human Services, Mental Health /Substance Abuse Division to obtain consumer input into the provision and quality of services. The Virginia Beach Department of Human Services, Mental Health/Substance Abuse Division has a very active Consumer and Family Affairs Office that advocates on a state and local level for the seriously mentally ill.

## PATH Budget
## 9/1/04 - 8/31/05

| Category | | | PATH Funded Amount | Non-Federal Direct Match | Source of Match Cash or in-Kind |
|---|---|---|---|---|---|
| **Staff Title** | **Annual Salary** | **FTE** | | | |
| Clinician II | | 1.00 | | | CASH |
| **TOTAL PERSONNEL** | | | | | In-Kind |
| **TOTAL FRINGE BENEFITS** | | | | | In-Kind |
| | | | | | |
| **Travel** | | | | | |
| Outreach | | | | | |
| Travel to meetings, training | | | | | |
| | | | | | |
| **Equipment** | | | | | |
| Cellphone | | | | | |
| | | | | | |
| **Supplies** | | | | | |
| Office Supplies | | | | | |
| Computer Maintenance | | | | | |
| | | | | | |
| **Contractual** | | | | | |
| | | | | | |
| **Other** | | | | | |
| Housing ( one time rental assistance, emergency shelter | | | | | |
| Psychiatric evaluations/medications<br>Maintenance and gas for vehicle use for outreach<br>Miscellaneous: bus tokens, food coupons, clothing, emergency medications, haircuts, sleeping bags. | | | | | |
| **Total PATH Budget** | | | **PATH** **$ 48,906** | **Match** **$ 16,302** | **$63,993** |

# Appendix F: Agreements

FISCAL YEAR 2004
PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH)
AGREEMENT

I hereby certify that the State of Virginia agrees to the following:
Section 522(a). Amounts received under the PATH Formula Grant Program will be expended solely for making grants to political subdivisions of the State, and to nonprofit private entities for the purpose of providing the services specified in Section 522(b) to individuals who

(1) (a) are suffering from serious mental illness; or (b) are suffering from serious mental illness and have a substance use disorders; and
(2) are homeless or at imminent risk of becoming homeless.

Section 522(b). Entities receiving grants under the PATH Formula Grant Program will expend funds for the following services:

(1) outreach;

(2) screening and diagnostic treatment;

(3) habilitation and rehabilitation;

(4) community mental health;

(5) alcohol or drug treatment;

(6) staff training, including the training of individuals who work in shelters, mental health clinics, substance abuse programs, and other sites where homeless individuals require services;

(7) case management services, including

(a) preparing a plan for the provision of community mental health services to the eligible homeless individual involved, and reviewing such plan not less than once every 3 months;

(b) providing assistance in obtaining and coordinating social and maintenance services for the eligible homeless individuals, including services relating to daily living activities, personal financial planning, transportation services, and habilitation and rehabilitation services, prevocational and vocational services, and housing

(c) providing assistance to the eligible homeless individual in obtaining income obtaining income support services, including housing assistance, food stamps, and supplemental security income benefits;

(d) referring the eligible homeless individual for such other services as may be appropriate; and

(e) providing representative payee services in accordance with Section 1631(a)(2) of the Social Security Act if the eligible homeless individual is receiving aid under Title XVI of such act and if the applicant is designated by the Secretary to provide such services.

(8) supportive and supervisory services in residential settings;

(9) referrals for primary health services, job training, education services and relevant housing services;

(10) housing services [subject to Section 522(h)(1)] including

(a) minor renovation, expansion, and repair of housing;

(b) planning of housing;

(c) technical assistance in applying for housing assistance;

(d) improving the coordination of housing services;

(e) security deposits;

(f) the costs associated with matching eligible homeless individuals with appropriate housing situations; and

(g) l-time rental payments to prevent eviction.

(11) other appropriate services, as determined by the Secretary.

Section 522(c). The State will make grants pursuant to Section 522(a) only to entities that have the capacity to provide, directly or through arrangements, the services specified in Section 522(b), including coordinating the provision of services in order to meet the needs of eligible homeless individuals who are both mentally ill and suffering from a substance abuse disorder.

Section 522(d). In making grants to entities pursuant to Section 522(a), the State will give special consideration to entities with a demonstrated effectiveness in serving homeless veterans.

Section 522(e). The State agrees that grants pursuant to Section 522(a) will not be made to any entity that

(l) has a policy of excluding individuals from mental health services due to the existence or suspicion of a substance abuse disorder; or

(2) has a policy of excluding individuals from substance abuse services due to the existence or suspicion of mental illness.

Section 522(f). Not more than 4 percent of the payments received under the PATH Formula Grant Program will be expended for administrative expenses regarding the payments.

Section 522(g). The State will maintain State expenditures for services specified in Section 522(b) at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying to receive such payments.

Section 522(h). The State agrees that

(l) not more than 20 percent of the payments will be expended for housing services under Section 522(b)(10); and

(2) the payments will not be expended

(a) to support emergency shelters or construction of housing facilities;

(b) for inpatient psychiatric treatment costs or inpatient substance abuse treatment costs; or

(c) to make cash payments to intended recipients of mental health or substance abuse services.

Section 523(a). The State will make available, directly or through donations from public or private entities, non-Federal contributions toward such costs in an amount that is not less than $l for each $3 of Federal funds provided in such payments. The amount of non-Federal contributions shall be determined in accordance with Section 523(b).

Section 523(c). The State will not require the entities to which grants are provided pursuant to Section 522(a) to provide non-Federal contributions in excess of the non-Federal contributions described in Section 523(a).

Section 526. The State has attached hereto a statement

(l) identifying existing programs providing services and housing to eligible homeless individuals and gaps in the delivery systems of such programs;

(2) containing a plan for providing services and housing to eligible homeless individuals, which

(a) describes the coordinated and comprehensive means of providing

services and housing to homeless individuals; and

(b) includes documentation that suitable housing for eligible homeless individuals will accompany the provision of services to such individuals;

(3) describing the source of the non-Federal contributions described in Section 523;

(4) containing assurances that the non-Federal contributions described in Section 523 will be available at the beginning of the grant period;

(5) describing any voucher system that may be used to carry out this part; and

(6) containing such other information or assurances as the Secretary may reasonably require.

Section 527(a) (1), (2), and (3). The State has attached hereto a description of the intended use of PATH Formula Grant amounts for which the State is applying. This description

(l) identifies the geographic areas within the State in which the greatest numbers of homeless individuals with a need for mental health, substance abuse, and housing services are located; and

(2) provides information relating to the programs and activities to be supported and services to be provided, including information relating to coordinating such programs and activities with any similar programs and activities of public and private entities.

Section 527(a)(4). The description of intended use for the fiscal year of the amounts for which the State is applying will be revised throughout the year as may be necessary to reflect substantial changes in the programs and activities assisted by the State pursuant to the PATH Formula Grant Program.

Section 527(b). In developing and carrying out the description required in Section 527(a), the State will provide public notice with respect to the description (including any revisions) and such opportunities as may be necessary to provide interested clients, such as family members, consumers and mental health, substance abuse, and housing agencies, an opportunity to present comments and recommendations with respect to the description.

Section 527(c)(1)(2). The services to be provided pursuant to the description of the intended use required in Section 527(a), have been considered in the preparation of, have been included in, and are consistent with the State Plan for Comprehensive Community Mental Health Services under P.L. 102-321.

Section 528(a). The State will, by January 31, 2005, prepare and submit a report providing such information as is necessary for

(l) securing a record and a description of the purposes for which amounts received under the PATH Formula Grant Program were expended during fiscal year 2004 and of the recipients of such amounts; and

(2) determining whether such amounts were expended in accordance with the provisions of Part C - PATH.

Section 528(b).

The State further agrees that it will make copies of the reports described in Section 528(a) available for public inspection.

Section 529. Payments may not be made unless the State agreements are made through certification from the chief executive officer of the State.

**Charitable Choice Provisions:**
The State will comply, as applicable, with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Charitable Choice statutes codified at sections 581-584 and 1955 of the Public Health Service Act (42 U.S.C. §§290kk, et seq., and 300x-65) and their governing regulations at 42 C.F.R. part 54 and 54a respectively.

_____ _____

Governor Date